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ABSTRACT

In 1992 CityMatCH, a national organization of urban maternal and child health programs and leaders, initiated a survey of programs to serve as an information resource for urban public health practitioners. This report updates previous data, presents baseline information on maternal and child health (MCH) programs in urban health departments serving areas with populations under 200,000, and provides comprehensive information on childhood immunization in urban communities. Section 1 describes the survey and technical issues, with an overview of findings on urban MCH programs. Section 2 contains descriptions of self-reported successful urban health department immunization initiatives. Section 3 contains contact information for major urban MCH programs, as well as key survey findings and recommendations. Leadership of urban MCH programs continues to change from year to year, but organizations remain fairly stable. State and local funds support the majority of MCH programs. About half of American's urban children are estimated to be fully immunized at 24 months of age, with 94 percent immunized at school entry. Over 75 percent of responding urban health departments reported experiencing a shift from private to public sectors in the delivery of immunization services. Seven tables and three figures illustrate the discussion. Appendixes contain the survey instrument and a list of surveyed health departments. (SLD)

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MCHB

WHAT WORKS II

1992
URBAN MCH PROGRAMS

FOCUS ON IMMUNIZATION

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CityMatCH

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CityMatCH is a national organization of urban maternal and child health programs and leaders. CityMatCH was initiated in 1988 to address the need for increased communication and collaboration among urban and maternal and child health programs for the purpose of improving the planning, delivery, and evaluation of maternal and child health services at the local level. CityMatCH, through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for addressing the health concerns of urban families and children. For more information about CityMatCH, contact Magda Peck, CityMatCH Executive Director, Department of Pediatrics, University of Nebraska Medical Center, 600 South 42nd Street, Omaha, NE 68198-2170, Telephone (402) 559-8323.

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PREFACE

Urban children and their families – be they in Atlanta, Akron or Albuquerque – face similar barriers to comprehensive primary and preventive health services, and these urban families often rely on similar public health systems for care. Maternal and child health programs in city and county health departments nationwide often are the critical health care link for these urban families. Despite notable differences in demographics, geography, and health systems across America's cities, there is a shared core of challenges and responsibilities that form a common bond among urban MCH programs and their leaders. This bond, if recognized and nurtured, can form the basis for highly productive cooperation and collaboration among urban communities that will enhance their capacity to serve urban women, infants and children.

City**MatCH**, a national organization of urban maternal and child health programs in major city and county health departments, was initiated in 1988 to strengthen the bond among urban MCH leaders. City**MatCH** provides an effective mechanism for communication and collaboration across U.S. cities in maternal and child health. Through the exchange of timely information about what works, and what doesn't, successful solutions to transportation barriers to primary care in our nation's capital have been translated and adapted to solve similar problems in Philadelphia. San Antonio's effective immunization strategies have been shown to work as well in Santa Ana and Anaheim. Indianapolis and Seattle have shared successful strategies to reduce infant mortality.

One City**MatCH** strategy for information exchange has been our annual survey of urban maternal and child health programs in major city and county health departments nationwide. In 1992, under our Cooperative Agreement for Information and Communication with the Maternal and Child Health Bureau of the Health Resources and Services Administration (the "Municipal MCH Partners Project"), we conducted our third national urban MCH survey. As in 1989 and 1990, we collected informa-

tion on the organization, leadership and financing of MCH services in urban health departments. The 1992 survey also focused on a significant public health challenge facing the nation: childhood immunizations.

What Works II: 1992 Urban MCH Programs is a resource document intended to provide current information about urban MCH programs and their most successful immunization initiatives which target urban families and children. It also is intended to facilitate communication among urban MCH leaders and others concerned about the health and well-being of urban children and their families, by providing contact information for the MCH leadership in urban health departments. City**MatCH** will continue to provide similar timely information so that local level MCH programs serving similar populations can benefit from the experiences of their counterparts in other parts of the country.

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City**MatCH** Executive Director

Elice D. Hubbert, MPA
Project Coordinator,
"Municipal MCH Partners Project"

ACKNOWLEDGMENTS

What Works II: 1992 Urban MCH Programs represents the efforts of many individuals who worked closely to complete the follow-up survey and compile its results. Urban MCH program directors and other MCH colleagues on the "Municipal MCH Partners Project" Advisory Committee - helped give the survey its shape and meaning. MCH leaders from the Association of Maternal and Child Health Programs, the National Association of County Health Officials, and the U.S. Conference of Local Health Officers were particularly helpful.

Fiscal and technical support from the Maternal and Child Health Bureau, Health Resources and Services Administration (MCU #316058-02-0) was essential to conducting the survey and disseminating its results. Additional input from Walter Orenstein, CDC; Edgar Marcuse, University of Washington; and Kay Johnson, March of Dimes, added to the quality of the study.

City**MatCH** staff at the University of Nebraska Medical Center were instrumental in completing the survey in a timely and highly competent fashion. Graduate Assistant Harry Bullerdiek did data entry and management, and helped with writing. Data Analyst Fred Ullrich provided essential programming expertise. Administrative Technician Joan Rostermundt provided assistance with survey administration, word processing, and document dissemination. Graduate Assistant Christina Kerby, Staff Assistant Barbara Sims, and Secretary Diana Fisaga provided additional support. Mark Watson and Martie Thompson with Printing and Duplicating Services at the University of Nebraska Medical Center managed the design, typesetting, and printing of the final document.

The original photographs used in this book were taken by Pamela J. Berry. The photographs on pages 9, 33, 41, 55 and 111 previously appeared in *HIDE & SEEK: The State of the Child in Nebraska 1992* by Voices for Children in Nebraska, 14643 Grover Street, Omaha, NE 68144.

Last, we must acknowledge the tremendous participation of urban MCH leaders in city and county health departments nationwide who once again shared their knowledge and their stories with us. With an over 90% response rate among larger cities, and an 80% response rate overall, we have great confidence that the information in *What Works II* fully reflects the universe of thought among urban MCH leaders in America's cities.

WHAT WORKS II: 1992 URBAN MCH PROGRAMS

Focus on Immunization

EXECUTIVE SUMMARY

Background

In May 1992 CityMat**CH** initiated its third national survey of urban maternal and child health (MCH) programs in the United States. *What Works II: 1992 Urban MCH Programs* is based upon information gathered from urban health departments across the country in response to the 1992 City**MatCH** Survey of Maternal and Child Health in Major Urban Health Departments in the United States. *What Works II* is designed to be an information resource for urban public health practitioners and others interested in maternal and child health at the local level. The 1992 survey builds upon information gained in earlier City**MatCH** surveys in 1989 and 1990.

The 1992 survey was funded under the "Municipal MCH Partners Project," the joint City**MatCH**/U.S. Conference of Local Health Officers (USCLHO) Partnership for Information and Communication (PIC) Cooperative Agreement (MCU #3160580240) with the Federal Maternal and Child Health Bureau (MCHB). The survey had three key purposes: (1) to update information obtained in the 1989 and 1990 City**MatCH** urban MCH surveys about the organization, leadership, and financial resources of urban MCH programs and to identify the major MCH problems faced by urban children and families; (2) to obtain baseline information on the status of MCH programs in urban health departments serving smaller urban areas (those with populations under 200,000) not previously surveyed by City**MatCH**; and, (3) to obtain comprehensive information on a single focal area in MCH: childhood immunization in urban communities.

A written questionnaire was mailed to all urban health departments having jurisdiction over one or more cities with populations greater than 100,000 according to the 1990 U.S. Census, the health department serving the largest city in the nine remaining states with no city large enough to meet the 100,000 population threshold, and the health department serving the largest city in three U.S. Territories, including Puerto Rico (a total of 177 health departments). An overall response rate of 80% was achieved; 100% of health departments serving cities with populations greater than 500,000 responded.

Section 1 describes the survey methods, response rate, and provides technical information about how the data were analyzed. It provides an overview of survey findings on the leadership, organization, and financing of urban MCH programs and highlights the immunization findings. Descriptions of self-reported successful urban health department initiatives to improve the levels of childhood immunization are presented in Section II. Section III contains contact information for major urban MCH programs and their leaders. Key survey findings and recommendations follow.

THE STATUS OF URBAN MCH PROGRAMS: 1992 UPDATE

Leadership

- **The leadership of MCH programs in urban health departments continues to undergo substantial change from year to year.** Approximately 54% of responding health departments serving populations >200,000 indicated the leadership of their MCH program had changed since the 1990 City**MatCH** urban MCH survey was conducted; 10% said no one person was MCH director.

Organization

- **The organization of MCH programs and activities in major urban health departments remains fairly stable.** Only 24% of responding health departments reported a change in the organization of their maternal and child health programs and activities since 1990.

Funding for MCH

- **The level of funding for urban MCH programs in the U.S. varies widely, but on average, health departments devote 25.5% of their total operating budgets to MCH activities.** Between FY'91 and FY'92, only 36% of all responding health departments reported increases in their MCH budgets; 8% reported budget decreases.

- **State and local funds support the majority of urban MCH program activities.** Across responding urban health departments in FY '92, 41% of MCH support was supplied by States (including State Title V Block Grant Funds), and 40% of MCH support was supplied by local governments. On average, only 5% of urban health department MCH support comes from direct Federal funds.

- **Third party reimbursement dollars (insurance, Medicaid) are generated by MCH activities in 93% of responding health departments.** However, these third party dollars are dedicated to MCH programs by only 43% of responding urban health departments.

Leading Urban MCH Problems

- **Lack of access to health care services and the impact of poverty on urban families were identified equally as the greatest MCH problem faced by urban children and families**. Infant mortality, low birthweight, inadequate prenatal care, adolescent pregnancy, substance abuse, and poor immunization levels were the next most often cited urban MCH problems.

CHILDHOOD IMMUNIZATION IN URBAN COMMUNITIES: MAJOR FINDINGS

Immunization Levels

- **About half (54%) of America's urban children are estimated to be fully immunized at 24 months of age.** Across cities with populations over 800,000, the levels of immunization are estimated to be even lower (39%).
- **At school entry, 94% of urban children are estimated to be fully immunized**. The principal sources of data about immunization levels are school and preschool record audits and kindergarten-based retrospective studies. Immunization data are not available by race or ethnicity in most responding health departments.

Children Served

- **Urban health departments experienced substantial increases in both the number of children served and the number of doses of vaccine administered between 1989 and 1991.** A 22% increase in the median estimated number of children served and a 44.5% increase in the median estimated number of doses of vaccine administered occurred between 1989 and 1991.

Service Providers

- **Private physicians are the principal providers of *primary/preventive* health care services for half (50%) of urban children.** Local health departments, hospital outpatient clinics, and community health centers are also primary providers of these services. Hospital emergency rooms are estimated to provide primary/preventive care for 3% of urban children nationwide.
- **Local health departments are the principal providers of *immunization services* for urban children; 41% of urban children receive their immunizations from the local health department**. Private physicians, hospital outpatient clinics, and community health centers also play important roles in immunizing urban children.

Private-Public Sector Shift

- **Over three-fourths (78%) of responding urban health department jurisdictions reported experiencing a shift from the private to the public sector in the delivery of immunization services.** The increased cost of vaccine in the private sector was cited as one of the principal reasons for this shift. Other reasons for the shift included poor reimbursement levels, liability concerns, and burdensome administration requirements.

Collaboration

- **Almost three-quarters (73%) of responding urban health departments reported that various providers of immunization services collaborate somewhat or a great deal.** Larger health departments reported higher levels of collaboration between health care providers.

Capacity

- **Only 57% of responding urban health departments reported having adequate capacity in 1992 to serve all children in their jurisdictions who seek immunization services from them.** Only one of the twelve health departments representing cities over 800,000 reported having adequate capacity.

Immunization Funding

- **Funding for local health department immunization activities increased in only 29% of responding urban health departments from 1989 to 1991; it decreased in 7%.**

Immunizations Administered

- **98% of responding urban health departments reported administering DPT, OPV/IPV, and MMR immunizations; 97% administer Haemophilus influenzae b (Hib) vaccine; 95% administer Td; and, 86% administer Hepatitis B vaccine**. Of those administering Hepatitis B, only 13% provide it to all infants.

  55% of urban health departments said they planned to provide universal Hepatitis B immunization to children in the future.

Barriers to Age-Appropriate Immunization

- **The greatest barrier to age-appropriate immunization faced by urban children and families according to responding health departments is a lack of parental education about the importance of childhood immunization**. Other identified immunization barriers included inadequate access to care; increased vaccine costs; overburdened, unfriendly delivery systems; and missed opportunities to vaccinate.

Needed Health Department Resources

- **To assure better age-appropriate immunization levels in children, urban health departments need computer tracking and recall systems; more staff and more clinic locations, with extended service hours; and, expanded outreach and education efforts** .

Childhood Immunization Initiatives

- **Examples of successful initiatives undertaken by urban health departments to improve childhood immunization levels abound.** The initiatives revolve around four basic strategies: improving the immunization delivery system; expanding outreach and education; building and utilizing community partnerships and coalitions; and better immunization documentation. Successful immunization initiatives often combine multiple strategies.

Conclusions and Recommendations

That on average half of urban children are not properly immunized by their second birthday is an unacceptable individual risk for each of these children and their families, and an intolerable marker of inadequate access to and utilization of basic preventive pediatric health care in cities, large and small, across the United States. Urban families and children rely on city and county health departments to provide basic primary and preventive health care services such as immunizations.

- **As the principal provider of immunizations to children in urban communities, city and county health departments need sufficient resources to meet an increasing demand for immunization services.** Urban health departments must, at a minimum, have sufficient funding, vaccine and personnel to allow for expansion of immunization hours and clinics, sites of delivery and outreach activities tailored to their individual communities' needs.

Private physicians continue to be the principal providers of primary health care to urban children. Yet children and their families in most American cities are being shunted away from their medical homes in the private sector to clinics in the public sector for immunization services due to concerns over vaccine costs, inadequate reimbursement, increasing administrative burdens associated with vaccine administration, and perceived risk of liability. This shift has not been experienced in several urban communities where vaccine is universally available in the private and public sectors alike and where collaboration between public and private sectors is high.

- **Urban children should be guaranteed access to immunization services in the public and private sectors, in part through the implementation of universal provision of vaccines, including universal purchase and distribution policies and programs.** Until that time when shifting between sectors for immunizations is minimized, increased and sustained collaboration between providers in the public and private sectors will be essential to ensure coordination and continuity in the delivery of primary and preventive health care services for urban children.

Shortcomings in services delivery not withstanding, insufficient parental awareness of the continued critical importance of immunizing

their young children persists as a significant barrier to age-appropriate immunizations in urban communities.

- **Consumer education, community-wide outreach, comprehensive tracking, and ongoing follow-up are key strategies which, if combined, can enable parents and empower communities to be full partners in the quest to eliminate vaccine-preventable diseases in children.** When childhood immunizations come to be valued as a resource which is as fundamental to the health of urban communities as clean drinking water, individual parental awareness of the importance of immunizing their children likely will increase.

Many urban health departments nationwide are improving their efforts to increase age-appropriate immunization levels among children in their jurisdictions. *What Works II* lists and categorizes over one hundred successful ways city and county health departments are making a difference by improving the immunization delivery system, expanding outreach and community education, facilitating community-based partnerships, and enhancing tracking and recall efforts.

- **There is no single "quick fix" to improving immunization levels among urban children, rather comprehensive, multi-faceted, longer term approaches are needed to make and sustain a difference.** Urban health departments should review their current strategies to identify gaps in current efforts. City and county health departments serving major urban areas should tap the expertise and experience of their counterparts in other urban communities to fill these gaps. Descriptions of successful immunization activities contained in *What Works II* will provide an invaluable tool for promoting communication and collaboration on childhood immunizations across urban areas in the U.S.

INTRODUCTION

What Works II: 1992 Urban MCH Programs is designed to inform and assist urban public health practitioners and others interested in urban maternal and child health. It contains current information about the leadership, organization and activities of MCH programs in urban city and county health departments across the country, and specifically focuses on childhood immunization in America's urban areas. In addition to quantitative findings on important immunization issues such as immunization levels and administrative practices, *What Works II* highlights the initiatives undertaken by urban health departments nationwide to improve childhood immunization levels in their jurisdictions. The information in *What Works II* is based upon the results of the 1992 CityMatCH Survey of Maternal and Child Health in Urban Health Departments in the United States.

Section I: Highlights of the 1992 CityMatCH Survey

Chapter 1: About the 1992 Survey provides an overview of the background, purposes and methodology behind the 1992 survey. A conceptual framework for understanding the methodological and technical issues relating to the data analysis is presented.

Chapter 2: Current Status of Urban MCH Programs: Part 1 of the 1992 Survey provides aggregate information about the leadership, program organization, and fiscal resources of urban MCH programs. The principal MCH problems facing urban families are identified and ranked. The chapter includes an "information at a glance" section which summarizes financial and demographic information for responding urban health departments.

Chapter 3: Childhood Immunization in Urban Communities: Part 2 of the 1992 Survey provides aggregate information about levels of childhood immunization, integration of immunization with other child health services, and the roles of public and private sector providers in the delivery of immunization services to children along with information about types of immunizations administered and methods and guide-

lines for administration. Responding health departments identify what they view as the principal barriers to age-appropriate immunization of children in their jurisdictions and what health departments need to do a better job of immunizing the children they serve.

Section II: Initiatives to Improve Childhood Immunization Levels

This Section presents "what works in immunizations," urban health department immunization success stories. These brief descriptions highlight successful current initiatives to improve childhood immunization levels. The initiatives are divided into four categories of strategies: Initiatives to Improve the Immunization Delivery System; Initiatives to Expand Community Outreach and Public Awareness; Initiatives to Build Community Collaborations and Coalitions; and Initiatives to Improve Immunization Documentation. For quick reference, the chapter contains a master index of immunization initiatives and the health departments which have instituted them.

Section III: Directory of Urban MCH Programs and Leaders

This section provides MCH program contact information for each surveyed health department. The directory can be used as a stand-alone resource to facilitate communication between local urban MCH leaders and others interested in urban MCH.

HIGHLIGHTS OF THE 1992 CITYMATCH SURVEY

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CHAPTER 1
ABOUT THE 1992 SURVEY

Background

In 1992, CityMat**CH** initiated its third national survey of urban maternal and child health (MCH) programs in the United States. The survey was funded under the "Municipal MCH Partners Project," the joint City**MatCH**/U.S. Conference of Local Health Officers Partnership for Information and Communication (PIC) Cooperative Agreement with the Federal Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS).

The 1992 City**MatCH** survey had three key purposes: (1) to update information obtained in the 1989 and 1990 City**MatCH** surveys of urban MCH programs in major city and county health departments in the United States;[1] (2) to obtain baseline information on the status of MCH programs in smaller urban health departments not previously surveyed by City**MatCH** (those with jurisdiction over cities with populations between 100,000 and 200,000); and, (3) to obtain baseline information on a single focal area in MCH: childhood immunization in urban communities.

Methodology

In May, 1992, a written questionnaire was mailed to 177 urban health departments (UHD).[2] Health departments surveyed included all urban health departments having jurisdiction over one or more cities with populations greater than 100,000 according to the 1990 U.S. Census (a total of 165 health departments representing 195 major cities with populations above the 100,000 threshold);[3] nine health departments serving the largest city in any State not otherwise represented;[4] and, to San Juan,

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[1]These surveys collected information about the organization, leadership, and resources of MCH programs in major urban health departments. They also gathered information about the major MCH problems experienced by the urban families served by the responding health departments. The 1990 survey also gathered information about successful urban MCH program initiatives. Its results were published as *What Works: 1990 Urban MCH Programs*. Results from the 1989 survey were published as the *Resource Directory of Major Urban MCH Programs*.

[2]A copy of the survey instrument can be found in Appendix A of this document. A list of the surveyed health departments is contained in Appendix B.

[3]Eleven health departments have multiple cities > 100,000 within their jurisdictions; seven of these are located in California, two in Florida, one in Arizona, and one in Michigan.

[4]These include Delaware, Maine, Montana, North Dakota, New Hampshire, South Carolina, Vermont, West Virginia, and Wyoming.

Puerto Rico, and the largest city in two other U.S. Territories (Guam and the Marshall Islands).[5] Of the surveyed health departments, 93 (53%) were surveyed by CityMatCH in 1989 and 1990;[6] 84 health departments (47%), most with populations between 100,000 and 200,000, were surveyed for the first time in 1992.

The survey was directed to the health department's designated MCH leader, if known. If the name of a designated MCH person was not available, the survey was directed to the health department's health officer. Those health departments not responding to the initial mailing were sent a second survey; those still not responding received a third survey. Three "fax reminders" were also sent encouraging health departments to complete and return their surveys.

The survey instrument consisted of two parts. Part 1 requested descriptive information about each health department's organization, mandate, financing and principal maternal and child health problems. Part 2 requested information about childhood immunizations and general child health. This section requested baseline information about childhood immunization levels, financing of immunization services, integration of immunization with other child health services, the roles of the public and private sector in the delivery of immunizations to children, and perceived barriers to age-appropriate immunization. Each health department was asked to share a "success story" related to immunization efforts in its urban community.

Table 1.1
Survey Response by Population of Cities in Urban Health Department (UHD) Jurisdictions

City Size*	Number of UHDs Surveyed	Number of UHDs Responding	Response Penetrance Within Population Categories
US Territories**	3	2	67%
<100,000	9	6	67%
100,000 to 200,000	88	63	72%
200,001 to 300,000	22	20	91%
300,001 to 500,000	28	23	82%
500,001 to 800,000	15	15	100%
>800,000	12	12	100%
TOTAL	177	141	80%

* Combined population of all major cities >100,000 within health department jurisdiction.
** Includes San Juan, Puerto Rico, population >200,000.

[5] San Juan, Puerto Rico, has been included among the target cities in all CityMatCH surveys. Agana, Guam and Majuro, Marshall Islands responded to the 1990 CityMatCH survey and were again surveyed in 1992 for continuity.

[6] Previous CityMatCH surveys included 91 health departments representing the 75 largest cities in the U.S. (cities over 200,000 according to the 1986 Census) and 17 additional health departments representing the largest city in any state not otherwise represented, plus 9 U.S. Territories.

Survey Response

Of the 177 urban health departments surveyed, 141 completed and returned questionnaires for an overall response rate of 80%. Responses were received from 70 health departments representing 71 of the 76 (93%) largest cities in the country (populations over 200,000). 100% of health departments serving cities over 500,000 responded. Responses were also received from 71% (69) of the 97 health departments serving smaller U.S. cities (populations under 200,000) and from health departments in two U.S. territories. Responses were received from city and county health departments in 46 of the 50 States (92%), the District of Columbia, and the Territories of Puerto Rico and Guam.[7]

Aggregate results are presented for 140 of the 141 responding health departments.[8] These health departments represent cities with greatly varying populations. Each health department has been classified based on the 1990 Census population of its principal city.[9]

The population classifications are as follows: <100,000; 100,000-200,000; 200,001-300,000; 300,001-500,000; 500,001-800,000; >800,000. Table 1.1 on the preceding page shows the number of health departments surveyed in each population category, the number who responded, and the response percent within each size category. Table 1.2 reflects the relative weight of survey responses stratified by city size.

The overall survey response was equally divided between health departments representing cities with populations greater than 200,000 (large cities) and health departments representing cities with populations less than 200,000 (small cities).

Table 1.2
1992 Urban Health Department
Survey Responses Stratified by City Size*

City Size*	Percent of Total Survey Responses
<100,000	4%
100,000 to 200,000	45%
200,001 to 300,000**	15%
300,001 to 500,000	16%
500,001 to 800,000	11%
>800,000	9%
TOTAL	100%

* Combined population of all major cities >100,000 within health department jurisdiction.
** Includes San Juan, Puerto Rico, population >200,000.

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[7] New Hampshire, North Dakota, Montana, and Rhode Island are not represented.

[8] Agana, Guam has no separate urban health department structure and its response was excluded from these analyses.

[9] Population classifications for health departments representing multiple cities with populations >100,000 were determined by adding together the populations of all cities >100,000 within the health department jurisdiction.

Who Are Urban MCH Leaders?

There is great variation in MCH leadership across urban health departments. Who a health department considers its MCH leader ranges from the Commissioner or Director of Health to a clinical staff nurse, from a medical director to a program administrator. There is no single MCH leader in 19.2% of responding health departments. Almost two-thirds (63.2%) of these health departments serve smaller cities (between 100,000 and 200,000). The tenure of current urban MCH leaders averages 5.4 years, ranging from a few months to 28 years. The MCH director is a physician in one-third (33.6%) of responding health departments. MCH leaders in 46.6% of responding health departments were nurses (RN). Graduate level public health training (MPH) has been completed by 33.6% of urban MCH leaders. Table 2.1 details the professional degrees held by urban MCH Directors/Coordinators, stratified by city size.

CHAPTER 2
CURRENT STATUS OF URBAN MCH PROGRAMS:
PART 1 OF THE 1992 SURVEY

Table 2.1:
***Professional Degrees Held by MCH Directors/Coordinators in Major Urban Health Departments (UHDs)**
Stratified by City Size

City Size**	RN	MD	MPH	MSN	MPA	Other ***
All UHDs	46.6	33.6	33.6	15.5	6.0	21.6
<100,000	33.3	17.7	50.0	0	0	50.0
100,000 to 200,000	49.0	30.6	30.6	20.4	4.1	18.3
200,001 to 300,000	38.9	22.2	38.9	33.3	11.1	16.7
300,001 to 500,000	27.8	50.0	38.9	11.1	5.6	33.3
500,001 to 800,000	69.2	23.1	30.8	0	7.7	23.1
>800,000	25.0	58.3	33.3	16.7	8.3	8.3

* Each may have more than one degree.
** Combined population of all major cities >100,000 within health department jurisdiction
*** Includes PhD, MS, MA, MSW, BSN, BBA

Over half (54%) of urban MCH leaders identified in the survey were between 40 and 49 years of age. Most current urban MCH Directors are women (74.6%). Larger urban communities tend to exhibit more racial and ethnic diversity in their MCH leadership. The diversity of urban MCH leaders based in city and county health departments is reflected in Table 2.2.

Table 2.2
Racial and Ethnic Diversity of MCH Directors/Coordinators in Major Urban Health Departments (UHDs)
Stratified by City Size

City Size*	White	Black	Asian	Other**	Hispanic	Non-Hispanic
All UHDs	81.6	14.0	3.5	.9	4.7	95.3
<100,000	100.0	0	0	0	0	100.0
100,000 to 200,000	85.4	10.4	2.1	2.1	4.0	96.0
200,001 to 300,000	84.2	10.5	5.3	0	0	100.0
300,001 to 500,000	88.9	11.1	0	0	10.0	90.0
500,001 to 800,000	66.7	33.3	0	0	16.7	83.3
>800,000	54.5	27.3	18.2	0	0	100.0

* Combined population of all major cities >100,000 within health department jurisdiction.
** No examples provided.

For a complete listing of the current urban MCH program directors identified in the 1992 CityMatCH Survey, please see Section III, **"Directory of Urban MCH Programs and Leadership."**

Changes in Urban MCH Program Leadership and Organization

The MCH leadership in urban health departments undergoes substantial changes from year to year. Only 54.3% of health departments serving cities with populations >200,000 who responded to the 1990 CityMatCH survey reported that the person considered to be the director or coordinator of maternal and child health was the same person as reported in 1990. 10.2% of these health departments reported that no one person coordinated MCH.

The organization of maternal and child health programs and activities in major city and county health departments has remained fairly stable in the past two years. In over three-quarters (75.4%) of responding health departments, the organization of MCH was the same as it was in 1990. Health departments serving cities with populations between 200,000 and 300,000 reported the highest organizational stability (81%), while health departments serving cities over 800,000 reported the lowest (66.7%).

Fiscal Resources for Urban MCH

Fiscal Year '92 (FY'92) resources available to responding urban MCH programs are displayed by city, state, and population code at the end of this chapter. The health department's total operating budget, MCH budget, the estimated portion of health department funds dedicated to MCH activities, and the percent of change in MCH funding between FY'91 and FY'92 are listed. These data are an approximation of urban MCH resources and may not be fully comparable across jurisdictions. Each responding health department based its estimates on its own definition of "MCH activities" and used its own methods to derive funding levels. The figures do, however, provide a sense of the fiscal resources dedicated to MCH in major urban health departments in the U.S.

There is great variation in the level of funding for urban MCH programs in the U.S., not only across cities of different size, but within groups of cities of comparable size. The MCH budget increased between FY'91 and FY'92 in 35.6% of all responding health departments and decreased in 8.3%; the MCH budget remained about the same for one-half (50.8%). 5.3% did not know. Table 2.3 shows the estimated percentage of total health department operating budget allocated to MCH activities and the resulting dollar commitment (in thousands) for the responding health departments stratified by city size. Of note is the lower percentage of operating budget funds dedicated to MCH activities in cities with populations between 500,001 and 800,000.[10]

State and local funds support the majority of urban MCH program activities. Of responding health departments, 40.7% reported receiving State support, including Title V Block Grant dollars, and 39.7% said they received local gov-

Table 2.3
FY '92 Funding for Urban Health Department (UHD) MCH Activities
Stratified by City Size

City Size*	Percent UHD Budget Dedicated to MCH Activities	FY'92 Funds in Thousands (K) Dedicated to MCH Activities**
All UHDs	25.5%	2974K
<100,000	50.0%	625K
100,000 to 200,000	23.8%	1155K
200,001 to 300,000	25.0%	2832K
300,001 to 500,000	28.1%	5153K
500,001 to 800,000	20.7%	4347K
>800,000	30.0%	25200K

* Combined population of all major cities >100,000 within health department jurisdiction.
** Median Figures.

[10]This group of urban health departments also had the highest percentage of third party reimbursement dollars (66.7%) generated by MCH activities channeled away to the general fund and the lowest percentage dedicated back to MCH efforts (26.7%). MCH-generated third party dollars were relied upon more by these urban health departments (13.7%) to support MCH programs than any other group of cities.

ernment support for MCH in FY'92. Only 5.1% reported receiving direct federal revenues (e.g. SPRANS, 330 funds, federal grants). Private funding sources (e.g. foundations, donations, corporate contributions) contributed less than 1% to urban health department MCH activities in FY'92. Responding health departments in the smaller urban communities (populations under 200,000) received greater state support for MCH activities (42.1% compared to 39.3% for larger cities). Those in larger urban areas (populations over 200,000) received slightly more local city/county funding (40.7% compared to 38.7% for smaller cities).

MCH activities generate third party reimbursement dollars (insurance, Medicaid) in most responding health departments (92.9%). Third party dollars are dedicated to MCH programs in 42.9% of responding urban health departments and revert to a general fund in over half (50.7%). Health departments in urban areas with populations greater than 200,000 channel more MCH-generated third party dollars (56.3%) to a general fund than their counterparts in smaller urban areas (44.9%).

Greatest MCH Problems Faced By Urban Families

The greatest MCH problems* faced by urban children and their families in 1992:

- Access to health care services
- Poverty
- Infant mortality, low birthweight, and inadequate prenatal care
- Substance abuse
- Poor immunization levels

*as perceived by responding urban health departments

Each urban health department was asked to list, in rank order of importance, the five greatest MCH problems faced by the families it served. Lack of access to health care services and the impact of poverty on urban families tied as the most frequently reported, first-ranked problem, each reported by 22% of responding health departments, or 44% of total respondents. Problems associated with infant mortality, low birthweight, and inadequate prenatal care were reported by 16% of responding urban health departments. Adolescent pregnancy, substance abuse, and poor immunization levels were also frequently listed problems.

The 1992 problem rankings reflect some change from the 1990 responses. In 1990 the greatest MCH problem faced by urban families was identified as infant mortality and low birth weight. The change in rankings may reflect an actual shift in urban MCH problems, an increased awareness of certain problems by responding health departments, and/or be influenced by the input of smaller urban health departments which did not participate in the 1990 survey.

Fiscal Resources for Urban Maternal and Child Health Programs

CITY	STATE	POP	UHD FY92 BUDGET(K)	MCH FY92 BUDGET(K)	% FOR MCH	BUDGET CHANGE
ANCHORAGE	AK	3	11,000	330	03	same
BIRMINGHAM	AL	3	36,278	7,618	21	same
MOBILE	AL	2	13,200	1,320	10	inc
LITTLE ROCK	AR	2	*	*	*	unk
PHOENIX +.	AZ	6	21,438	5,145	24	same
TUCSON	AZ	4	12,851	3,984	31	inc
BAKERSFIELD	CA	2	*	*	*	same
CONCORD #	CA	2	21,000	4,200	20	dec
LONG BEACH	CA	4	19,194	2,303	12	inc
LOS ANGELES +	CA	6	2,200	*	*	inc
OAKLAND +	CA	5	63,000	15,750	25	inc
OXNARD #+	CA	4	11,000	5,500	50	same
PASADENA	CA	2	4,963	1,241	25	inc
RIVERSIDE	CA	3	*	*	*	unk
SACRAMENTO	CA	4	*	*	*	inc
SALINAS	CA	2	31,673	6,335	20	inc
SAN BERNARDINO +	CA	4	30,000	15,000	50	same
SAN DIEGO +	CA	6	227,508	27,301	12	inc
SAN FRANCISCO	CA	5	529,986	2,650	.5	same
SAN JOSE +	CA	6	166,000	*	*	unk
SANTA ANA +	CA	6	80,000	12,800	16	inc
SANTA ROSA	CA	2	16,800	4,200	25	same
VALLEJO #	CA	2	15,400	3,080	20	same
AURORA #	CO	3	7,200	2,160	30	same
COLORADO SPRINGS	CO	3	6,152	1,784	29	same
DENVER	CO	4	120,000	*	*	unk
LAKEWOOD	CO	2	*	*	*	unk
BRIDGEPORT	CT	2	5,000	3,250	65	same
HARTFORD	CT	2	6,897	3,311	48	inc
NEW HAVEN	CT	2	2,317	301	13	inc
STAMFORD	CT	2	3,000	300	10	same
WATERBURY	CT	2	3,505	1,507	43	inc
WASHINGTON	DC	5	114,000	19,380	17	same
WILMINGTON	DE	1	*	*	*	dec
JACKSONVILLE	FL	5	15,457	3,091	20	dec
MIAMI +	FL	4	29,831	8,651	29	same

POPULATION CODE: 1=<100K, 2=100K TO 200K, 3=>200K TO 300K, 4=>300K TO 500K,5=>500K TO 800K, 6=>800K

UHD FY92 BUDGET (K): Health department's total budget (1,000's) FY92

MCH FY92 BUDGET (K): Dollars (1,000's) dedicated to MCH activities FY92

BUDGET CHANGE: How MCH portion of total budget has changed in the past year: increased, same, decreased, or unknown

Largest city in health department's jurisdiction; health department located in different city

+ Health department jurisdiction includes multiple cities >100K; population code includes all cities >100K in service area

* Data not available

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Fiscal Resources for Urban Maternal and Child Health Programs

CITY	STATE	POP	UHD FY92 BUDGET(K)	MCH FY92 BUDGET(K)	% FOR MCH	BUDGET CHANGE
ORLANDO	FL	2	15,489	7,745	50	same
ST PETERSBURG	FL	3	19,000	7,600	40	same
TALLAHASSEE	FL	2	*	*	*	unk
TAMPA	FL	3	19,817	5,945	30	dec
ATLANTA	GA	4	43,856	5,263	12	same
SAVANNAH	GA	2	7,715	2,315	30	same
AGANA	GM	*	11,167	2,010	18	unk
HONOLULU	HI	4	424,457	38,201	09	inc
CEDAR RAPIDS	IA	2	*	*	*	unk
DES MOINES	IA	2	1,200	300	25	same
BOISE	ID	2	4,749	1,235	26	same
CHICAGO	IL	6	*	*	*	dec
PEORIA	IL	2	4,000	800	20	same
ROCKFORD	IL	2	*	*	*	inc
SPRINGFIELD	IL	2	*	*	*	inc
EVANSVILLE	IN	2	2,358	967	41	same
INDIANAPOLIS	IN	5	16,383	*	*	same
SOUTH BEND	IN	2	1,234	86	07	same
TOPEKA	KS	2	6,300	1,512	24	same
LEXINGTON	KY	3	12,290	1,475	12	same
LOUISVILLE	KY	3	12,111	3,754	31	inc
BATON ROUGE	LA	3	*	*	*	unk
NEW ORLEANS	LA	4	15,700	7,065	45	same
SHREVEPORT	LA	2	11,000	6,600	60	same
BOSTON	MA	5	21,000	3,780	18	inc
BALTIMORE	MD	5	112,258	22,452	20	inc
PORTLAND	ME	1	1,250	688	55	inc
ANN ARBOR #	MI	2	*	*	*	same
DETROIT	MI	5	88,000	*	*	unk
GRAND RAPIDS	MI	2	16,500	9,900	60	same
LANSING	MI	2	12,000	3,960	33	inc
LIVONIA #	MI	2	22,000	9,680	44	same
STERLING HEIGHTS #	MI	3	11,662	4,198	36	same
MINNEAPOLIS	MN	4	11,649	8,387	72	same
ST PAUL	MN	3	9,000	1,800	20	inc
INDEPENDENCE	MO	2	1,152	115	10	same

POPULATION CODE: 1 = < 100K, 2 = 100K TO 200K, 3 = > 200K TO 300K, 4 = > 300K TO 500K, 5 = > 500K TO 800K, 6 = > 800K

UHD FY92 BUDGET (K): Health department's total budget (1,000's) FY92

MCH FY92 BUDGET (K): Dollars (1,000's) dedicated to MCH activities FY92

BUDGET CHANGE: How MCH portion of total budget has changed in the past year: increased, same, decreased, or unknown

Largest city in health department's jurisdiction; health department located in different city

+ Health department jurisdiction includes multiple cities > 100K; population code includes all cities > 100K in service area

* Data not available

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Fiscal Resources for Urban Maternal and Child Health Programs

CITY	STATE	POP	UHD FY92 BUDGET(K)	MCH FY92 BUDGET(K)	% FOR MCH	BUDGET CHANGE
KANSAS CITY	MO	4	9,530	2,192	23	unk
SPRINGFIELD	MO	2	4,148	373	09	inc
JACKSON	MS	2		*	*	same
CHARLOTTE	NC	4	16,834	4,209	25	inc
DURHAM	NC	2	5,368	483	09	dec
GREENSBORO	NC	2	17,881	7,510	42	inc
RALEIGH	NC	3	20,000	6,600	33	inc
OMAHA	NE	4	4,100	820	20	same
JERSEY CITY	NJ	3	*	*	*	same
NEWARK	NJ	3	3,644	547	15	dec
PATERSON	NJ	2	3,276	328	10	same
ALBUQUERQUE	NM	4	*	*	*	unk
LAS VEGAS	NV	3	16,888	1,858	11	same
RENO	NV	2	241	7	03	same
BUFFALO	NY	4	18,341	6,053	33	same
NEW YORK	NY	6	278,700	36,231	13	dec
ROCHESTER	NY	3	30,920	4,638	15	inc
SYRACUSE	NY	2	36,532	3,288	09	same
YONKERS #	NY	2	19,588	3,722	19	inc
AKRON	OH	3	8,772	1,404	16	same
CINCINNATI	OH	4	34,103	3,751	11	inc
CLEVELAND	OH	5	6,400	2,496	39	inc
COLUMBUS	OH	5	23,565	2,828	12	same
DAYTON	OH	2	19,147	1,915	10	inc
TULSA	OK	4	8,039	884	11	inc
EUGENE	OR	2	1,863	503	27	same
PORTLAND	OR	4	45,562	21,414	47	inc
ALLENTOWN	PA	2	2,844	199	07	same
ERIE	PA	2	3,416	171	05	inc
PHILADELPHIA	PA	6	383,130	*	*	same
PITTSBURGH	PA	4	26,552	7,700	29	same
SAN JUAN	PR	3	82,589	9,085	11	same
COLUMBIA	SC	1	*	*	*	unk
SIOUX FALLS	SD	1	762	495	65	unk
CHATTANOOGA	TN	2	7,979	2,553	32	same
MEMPHIS	TN	5	16,800	*	*	same

POPULATION CODE: 1=<100K, 2=100K TO 200K, 3=>200K TO 300K, 4=>300K TO 500K,5=>500K TO 800K, 6=>800K

UHD FY92 BUDGET (K): Health department's total budget (1,000's) FY92

MCH FY92 BUDGET (K): Dollars (1,000's) dedicated to MCH activities FY92

BUDGET CHANGE: How MCH portion of total budget has changed in the past year: increased, same, decreased, or unknown

Largest city in health department's jurisdiction; health department located in different city

+ Health department jurisdiction includes multiple cities >100K; population code includes all cities >100K in service area

* Data not available

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Fiscal Resources for Urban Maternal and Child Health Programs

CITY	STATE	POP	UHD FY92 BUDGET(K)	MCH FY92 BUDGET(K)	% FOR MCH	BUDGET CHANGE
NASHVILLE	TN	5	16,995	3,399	20	inc
AMARILLO	TX	2	2,365	166	07	inc
AUSTIN	TX	4	38,000	*	*	same
BEAUMONT	TX	2	1,700	170	10	same
CORPUS CHRISTI	TX	3	6,446	2,578	40	same
DALLAS	TX	6	*	*	60	same
EL PASO	TX	5	12,784	1,023	08	inc
FORT WORTH	TX	4	8,733	1,572	18	same
GARLAND	TX	2	1,350	81	06	same
HOUSTON	TX	6	43,700	14,858	34	same
IRVING	TX	2	0	0	00	unk
LAREDO	TX	2	4,300	1,118	26	inc
LUBBOCK	TX	2	3,306	860	26	inc
MESQUITE	TX	2	85	*	*	dec
PASADENA	TX	2	10,179	1,527	15	inc
SAN ANTONIO	TX	6	20,560	10,486	51	inc
WACO	TX	2	3,548	426	12	inc
SALT LAKE CITY	UT	2	13,500	4,050	30	inc
ALEXANDRIA	VA	2	8,340	2,919	35	inc
CHESAPEAKE	VA	2	2,500	250	10	same
NEWPORT NEWS	VA	2	6,425	1,157	18	inc
NORFOLK	VA	3	8,954	2,507	28	dec
PORTSMOUTH	VA	2	3,196	192	06	same
RICHMOND	VA	2	6,500	2,600	40	same
VIRGINIA BEACH	VA	4	4,500	1,125	25	same
BURLINGTON	VT	1	*	*	*	unk
SEATTLE	WA	5	68,669	24,034	35	inc
SPOKANE	WA	2	9,888	3,362	34	same
TACOMA	WA	2	19,574	5,872	30	same
MADISON	WI	2	2,787	641	23	same
MILWAUKEE	WI	5	14,000	3,500	25	same
CHARLESTON	WV	1	2,800	560	20	inc
CHEYENNE	WY	1	530	398	75	same

POPULATION CODE: 1 = < 100K, 2 = 100K TO 200K, 3 = >200K TO 400K, 4 = >400K TO 500K, 5 = >500K TO 800K, 6 = >800K

UHD FY92 BUDGET (K): Health department's total budget (1,000's) FY92

MCH FY92 BUDGET (K): Dollars (1,000's) dedicated to MCH activities FY92

BUDGET CHANGE: How MCH portion of total budget has changed in the past year: increased, same, decreased, or unknown

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+ Health department jurisdiction includes multiple cities >100K; population code includes all cities >100K in service area.

* Data not available

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CHAPTER 3

CHILDHOOD IMMUNIZATION IN URBAN COMMUNITIES:

PART 2 OF THE 1992 SURVEY

Part 2 of the 1992 City**MatCH** Survey of Maternal and Child Health in Urban Health Departments in the United States focused on childhood immunization. Each urban health department was asked to provide information about childhood immunization services in its jurisdiction. For purposes of the survey, immunization services were broadly defined to include administration of vaccines to children, purchase and/or distribution of vaccine, outreach and education efforts, and other assurance and monitoring activities. Specific information was requested about the immunization status of children at 24 months and at school entry; about who the principal providers of immunization and primary/preventive health care services for children were; about the adequacy of health department capacity and the extent of collaboration with other providers; and about the sources and levels of financing of immunization activities. Health departments were asked to identify what they perceived to be the greatest barriers to age-appropriate immunization faced by children and families in their jurisdictions as well as to identify the resources needed by urban health departments to assure better childhood immunization levels. In addition, each health department was asked to describe its most successful activities to improve childhood immunization levels in its urban community. These "success stories" are presented in Section II, **"Initiatives to Improve Childhood Immunization Levels."**

Levels of Childhood Immunization

In your health department's jurisdiction, what percentage of children are fully immunized at 24 months of age?

Only about one-half (53.8%) of urban children were reported by responding city and county health departments as being fully immunized at 24 months of age. On average, health departments serving cities with populations under 200,000 reported only slightly higher 24 month immunization levels than health departments serving larger cities (54.9% compared to 52.9%)

The lowest 24 month immunization levels were reported by urban health departments serving cities with populations over 800,000. Only an average of 39.2% of children in those jurisdictions were reported fully immunized at 24 months of age. One responding health department of this size reported that only 18% of two-year -olds in its jurisdiction were fully immunized.

Figure 1

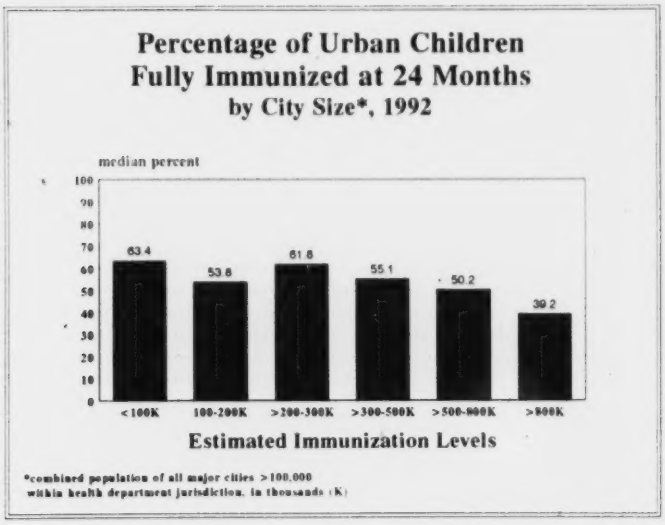


Figure 1 reflects average levels of immunization for two-year olds stratified by city size.

In your health department's jurisdiction, what percentage of children are fully immunized at school entry?

Overall, urban health departments reported that 94.3% of children in their jurisdictions were fully immunized when they entered school. Little variation in the school entry immunization level was noted by city size. Health departments indicated that their principal sources of information on levels of childhood immunization were school and preschool record audits and kindergarten-based retrospective studies. 85.7% of health departments reported that school entry immunization data was not available by race or ethnicity. Almost three-quarters (73.1%) of responding health departments indicated that 24 month immunization data was not available by race or ethnicity.

Half of urban children (51%) are estimated to receive their primary/preventive health care services from private physicians. Other principal providers of primary/preventive health care services, according to responding urban health departments, are local health departments (20%), hospital outpatient clinics (9%), and community health centers (9%). Local health departments played the greatest role in providing primary/preventive health services in cities with populations over 800,000 (30%) and in cities in the 200,000-300,000 population range (28%). Community health centers were most utilized in cities with populations between 500,000 and 800,000 (18.5%), resulting in lower private physician and local health department utilization (37% and 13% respectively). Hospital emergency rooms provide primary/preventive care for 3% of children across all responding health departments. Hospital-inpatient services are estimated to provide primary/preventive care for less than 1% of children nationwide.

City and county health departments are the primary providers of immunizations for urban children. Urban health departments provide immunizations to 41% of children in their jurisdictions. Private physicians provide immunizations for 37% of urban children. These are followed by hospital outpatient clinics (8%) and community health centers (8%). In urban communities with populations of less than 300,000, local health departments are estimated to provide immunizations to 48% of children. Community health centers again play a larger role in mid-sized (500,000-800,000 population) cities, providing immunizations to 18% of children and reducing private physician and health department utilization for immunization services, (29% and 28% respectively). Again, hospital inpatient services are estimated to provide less than 1% of childhood immunizations.

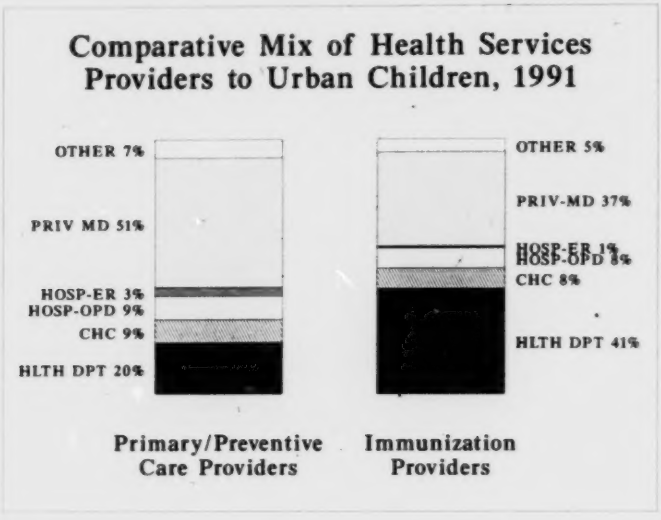
Providers of Health Care Services for Urban Children

Please estimate the percentage of children in your jurisdiction who received primary/preventive care, and the percentage who received immunizations, from the following providers in 1991:

- *from your city or county health department*
- *from community health centers*
- *from hospital-inpatient services*
- *from hospital-outpatient services*
- *from hospital-emergency room*
- *from private physicians*
- *from other providers*

Figure 2 reflects the comparative mix of providers of primary/ preventive health care and immunization services to urban children across all responding health departments.

Figure 2



Private/Public Sector Shift

In recent years, some urban communities have experienced a shift from the private to the public sector in the delivery of immunization services. Has this shift occurred in your jurisdiction?

Over three-fourths (78.4%) of urban health departments responding to the 1992 survey indicated their jurisdictions had experienced a shift from the private to the public sector in the delivery of immunization services. Health departments serving cities with populations between 500,001-800,000 reported a lower percentage of shift (57.1%). This may again be a function of a larger reliance on community health centers. A variety of explanations were given for the cause of this shift from the private to the public sector. These included:

- increased vaccine costs in the private sector
- poor levels of Medicaid reimbursement
- liability concerns of private physicians
- cumbersome informed consent requirements
- additional required vaccine doses based on changing immunization guidelines

In several health department jurisdictions where a shift was not experienced, the principal reasons were believed to be universal availabil-

ity of publicly funded vaccine and high levels of provider collaboration in the provision of immunization and other primary health care services for children.

Urban health departments across all population breakdowns reported substantial increases in the estimated numbers of children served and the estimated numbers of vaccine doses administered since 1989. Overall, responding urban health departments related a 22.1% increase in the median estimated number of children served and a 44.5% increase in the median estimated number of doses of vaccine administered from 1989 to 1991. In general, the largest increases were reported by health departments serving cities with populations of less than 300,000. Table 3.1 reflects the change between 1989 and 1991 in the median estimated number of children served and the median estimated number of doses of vaccine administered by health departments, stratified by city size. It should be noted, however, that a number of health departments indicated this series of questions was particularly difficult for them to answer due to the limitations of their data collection and tracking systems. Responding health departments expressed more confidence in the accuracy of their responses regarding "doses administered" than "number of children served."

Children Served/Doses of Vaccine Administered

How many children received immunizations and how many doses of vaccines have been administered through all of your health department's programs in each of the past three years (1989, 1990, 1991)?

Table 3.1
Change in Median Estimated Numbers of Children Served and Vaccine Doses Administered Across Responding Urban Health Department (UHD) Jurisdictions, 1989-1991

City Size*	% Change in Median Number of Children Served	% Change in Median Number of Vaccine Doses Administered
All Responding UHDs	+22.1%	+44.5%
<100,000	**	**
100,000-200,000	+43.5%	+46.2%
>200,001-300,000	+55.2%	+34.4%
>300,001-500,000	+29.5%	+27.9%
>500,001-800,000	**	+57.5%
>800,000	+23.4%	+23.9%

* Combined population of all major cities >100,000 within health department jurisdiction.
** N of responding health departments <5 - too small to report reliable finding.

Capacity of Urban Health Departments

Does your health department currently have the capacity to serve all children who seek immunization services?

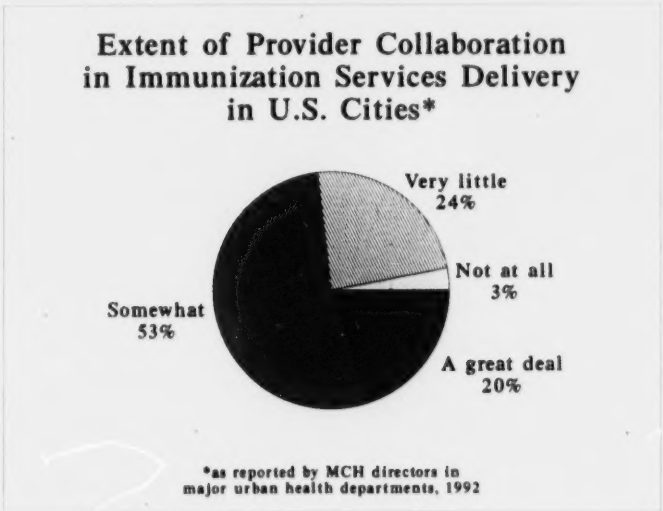
Only 56.9% of responding urban health departments said they had adequate capacity to serve all children seeking immunization services. While approximately two-thirds of smaller health departments reported having enough capacity, only one of the twelve health departments representing cities greater than 800,000 reported having adequate capacity to serve all children seeking immunization services from them. The relatively larger increases experienced by smaller urban health departments in numbers of children served and vaccine doses administered may, in part, be a result of having available capacity to provide service to additional children while larger health departments may virtually be fully extended in the amount of services they are able to provide.

Provider Collaboration in the Delivery of Immunization Services

To what extent do providers collaborate in the delivery of immunization services to children in your jurisdiction?

Providers collaborate somewhat or a great deal in 73.3% of responding urban health departments. Larger health departments reported higher levels of collaboration between providers. Health departments serving urban areas greater than 500,000 reported that immunization providers collaborated somewhat or a great deal 92.3% of the time, while only 70.9% of health departments serving areas under 500,000 reported high levels of collaboration. Figure 3 represents the extent of provider collaboration across all responding urban health departments.

Figure 3


Extent of Provider Collaboration in Immunization Services Delivery in U.S. Cities*
Very little 24%
Not at all 3%
Somewhat 53%
A great deal 20%
*as reported by MCH directors in major urban health departments, 1992

Responding health departments provided numerous examples of collaborative efforts in their jurisdictions. Examples of collaboration included:

- providing vaccine to others
- providing/accepting referrals and resource information
- collaborating in special programs and health fairs
- setting up community immunization advisory groups to identify barriers, formulate solutions and collaborate in implementation
- developing standard forms and record keeping systems
- information sharing including use of computerized data bases and developing portable immunization cards
- cooperation in submission of grant applications

Immunization Administration

What childhood immunizations does your health department currently administer?

97.9% of urban health departments responding to the 1992 City**MatCH** survey administer diphtheria/tetanus/pertussis (DPT), oral poliovirus/injectable poliovirus (OPV/IPV) and measles/mumps/rubella (MMR) immunizations; 97.1% administer Haemophilus influenzae b (Hib) vaccine; 95% administer tetanus/diphtheria (Td); and, 86.4% administer Hepatitis B vaccine to a specific group or groups. Health departments which do not directly administer these immunizations often provide the vaccine for others to administer.

To what groups does your health department currently administer Hepatitis B vaccine?

Health departments were asked to respond to several questions regarding the administration of Hepatitis B vaccine. Infants of Hepatitis B positive mothers were identified as the principal target group for receipt of Hepatitis B vaccine. Overall, 76.4% of responding health departments administer Hepatitis B vaccine to this group. 100% of health departments serving cities with populations over 800,000 provide the vaccine to this target group. Table 3.2 on the following page reflects the target groups to which urban health departments administer Hepatitis B vaccine.

Table 3.2
Administration of Hepatitis B Vaccine to Target Groups by Urban Health Departments (UHDs)

Target Groups Receiving Hepatitis B Vaccine From UHDs	Percent of UHDs Administering Hepatitis B Vaccine
Infants of Hepatitis B+ Mothers	76.4%
Infants of Refugees and Other High Risk Groups	30.0%
All Infants	12.9%
Adolescents	4.3%

Does your health department plan to provide universal Hepatitis B immunization to children?

Across all responding urban health departments, 55.1% indicated that they planned to provide universal Hepatitis B immunization to children. 8% of health departments said they did not plan to provide universal Hepatitis B immunization and 27.5% said that a decision had not yet been made or they did not know.

What immunization guidelines does your health department follow?

Urban health departments most commonly follow the guidelines of their individual state (82.1%) and the immunization guidelines of the Centers for Disease Control and Prevention, Advisory Committee on Immunization Practice (ACIP) (81.4%). The guidelines of the American Academy of Pediatrics (AAP) are followed by 59.3% of responding health departments.

How does your health department administer immunizations to children in your jurisdiction?

Health departments rely on several mechanisms for administering immunizations to children in their jurisdictions. 94.3% of responding health departments deliver immunizations through immunization clinics. 82.4% of respondents deliver immunizations through child health clinics. Special vaccination campaigns are used according to 60% of responding health departments, followed by primary care clinics (41.4%) and WIC clinics (29.3%).

Immunization Funding Trends

In the past three years, what has been the trend in the amount of funding for your local health department's immunization services?

While virtually all responding urban health departments reported increased numbers of children seeking immunization services, only 28.7% said the trend in funding for their health department immunization services had increased from 1989 to 1991. 7.3% indicated their immunization funding had decreased. The remainder indicated that funding for immunization services had remained stable.

Barriers to Age-Appropriate Immunization

Each health department was asked to identify what were perceived to be the three greatest barriers (in order of importance) to age-appropriate immunizations faced by children and families in their jurisdiction. The barrier most often identified by responding health departments was a lack of parental education about the importance of childhood immunization coupled with a lack of motivation to seek immunization services. Inadequate access to care (including transportation barriers) was the second most often identified barrier. Other principal barriers to adequate immunization were the increased costs of vaccine; overburdened and unfriendly delivery systems; and missed opportunities to vaccinate.

The greatest barriers* to age-appropriate immunization faced by urban children and their families:

- Lack of parental education about the importance of immunizations
- Inadequate access to care
- Increased vaccine costs
- Overburdened, unfriendly delivery systems
- Missed opportunities to vaccinate

*as perceived by responding urban health departments

Resource Needs of Urban Health Departments

What does your health department need to assure better age-appropriate childhood immunization levels in your jurisdiction?

Urban health departments need a variety of resources to assure better age-appropriate immunization levels in children. Computer tracking and recall systems are needed to enable health departments to target their efforts more effectively and measure progress. More staff and more clinic locations, with extended service hours, are needed to make it easier for working parents to have their children immunized. Expanded community outreach and increased community information and education efforts are needed to reach all segments of the population, particularly hard to reach high risk populations.

Initiatives to Improve Childhood Immunization Levels

What Urban Health Departments Are Doing to Improve Levels of Immunization:

- Creating more "user friendly" delivery systems
- Expanding immunization outreach and education activities
- Building and utilizing community partnerships, collaborations and coalitions
- Improving immunization documentation

Each health department was asked to describe its most successful activities to improve childhood immunization levels in its jurisdiction, its immunization "success story." Successful interventions often combined multiple strategies, but four basic categories of strategies emerged from the identified initiatives: initiatives to improve the delivery system or make it more "user friendly;" initiatives to expand community outreach and community education; initiatives involving community partnerships, collaborations and coalitions; and initiatives relating to immunization documentation such as developing tracking and recall systems and stricter enforcement of immunization standards. Section II, **"Initiatives to Improve Childhood Immunization Levels"** describes the creative actions local city and county health departments are taking to solve complex problems.

INITIATIVES TO IMPROVE CHILDHOOD IMMUNIZATION LEVELS

URBAN HEALTH DEPARTMENT IMMUNIZATION SUCCESS STORIES

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About This Section

"What Works" in Immunizations

Urban Health Department Immunization Success Stories

CityMatCH is committed to gathering and brokering information about "what works" in urban maternal and child health. Urban public health leaders, faced with tightening budgets and increasing demands for an ever expanding variety of services, have time and again met their challenges by devising creative new strategies and implementing innovative initiatives. We at CityMatCH believe there is much to be learned from these front line experts who daily battle the health and welfare problems faced by urban women and children. Toward this end, as with past CityMatCH surveys, the 1992 Survey of Maternal and Child Health in Urban Health Departments asked each health department to share a "success story." This year's success stories reflect what urban health departments believe to be their most successful activities to improve childhood immunization levels.

The initiatives highlighted in this Section are perceived to have been successful by the responding health departments. No specific measure of success was required other than a perception by the health department that their initiative seemed to be working.

Although the survey asked each health department to highlight only one initiative, multiple examples of successful activities were provided by several responding health departments. Whenever possible, all information given in each health department's survey response has been presented and the original wording of the responding health department has been maintained.

The activities have been subdivided into four basic descriptive categories for easier reference. While a single initiative may encompass several categories of activities, we have attempted to place each initiative into the category of primary focus.

An "initiatives-at-a-glance" matrix immediately precedes the initiative descriptions. This matrix lists each responding health department and provides quick, categorized information about the types of immunization initiatives the health department has undertaken. The matrix can be used in several ways. First, to identify the successful immunization activities of a specific city or county health department, and second, to identify all health departments who have undertaken specific types of initiatives.

- **Initiatives to Improve the Immunization Delivery System.**

In this subsection we present activities designed to make the immunization delivery system more "user friendly" and more easily accessible. Examples of the types activities contained under this heading include expanding hours, days, and service locations, offering "express lane" clinics to decrease waiting time, and attempting to minimize missed opportunities to vaccinate.

- **Initiatives to Expand Community Outreach and Public Awareness.**

The primary focus of the activities in this subsection is increasing public education and awareness about the importance of immunization and conducting community outreach activities. Examples include providing immunizations in non-traditional places such as parks and shopping malls, providing incentives to encourage parents to seek timely immunization for their children, as well as many creative examples of public information media campaigns.

- **Initiatives Involving Community Collaborations and Coalitions.**

This subsection details examples of immunization activities which involve community collaborations and coalitions. Many of the activities highlighted in this section relate to collaborative efforts in connection with submitting applications for new funding opportunities (such as the Centers for Disease Control's Infant Immunization Initiative).

◆ **Initiatives to Improve Immunization Documentation.**

Activities in this subsection focus on better collection and usage of immunization data. Immunization tracking and follow-up systems along with activities aimed at better enforcement of immunization standards are presented.

Descriptions within each subsection are presented in alphabetical order, first by State (or Territory) and then by the health department's principal City within the State (or Territory). In most instances the health department is located in the listed city. In a very few instances, however, a health department having jurisdiction for a city of greater than 100,000, may be physically located in a different, smaller city. These are generally county health departments. Because CityMatCH targets cities with populations greater than 100,000, the name of the largest city in the health department's jurisdiction is presented. The name of the city where the health department is actually located is given in an accompanying footnote. These cities are denoted by an asterisk (*). Several health departments are responsible for multiple cities of greater than 100,000 population, in these instances the additional cities are shown in parentheses below the name of the health department.

The descriptions that follow are brief sketches of the activities of each responding health department. They are not intended to be a comprehensive overview of these initiatives. The reader is encouraged to contact his or her urban MCH colleagues for more information about these activities. **Contact information for each surveyed urban health department is presented in Section III of this document.**

1992 Urban Health Department Immunization Initiatives

	Initiatives to Improve the Immunization Delivery System							Initiatives to Expand Community Outreach and Public Awareness									Initiatives Involving Community Collaboration			Initiatives to Improve Immunization Documentation				
	Add days, hours, locations	Walk-in clinics	Reduce time to get appointments	Reduce waiting time during clinics	Increase personnel	Reduce missed opportunities		Target special populations	Immunize at public service sites	Immunize at community-based sites	Use mobile van units	Do mass immunization campaigns	Increase incentives to parents	Increase consumer education	Mass media campaigns	Creative advertising campaigns	Public-private sector task forces/coalitions	Partnerships with schools, community organizations and others	Maximize I-3 planning and development	Audits (day care, WIC, etc.)	Recall/reminder systems	Tracking systems	Stricter standard enforcement	Other
Anchorage, Alaska															♦							♦		
Birmingham, Alabama															♦					♦				
Mobile, Alabama				♦	♦			♦						♦							♦			
Little Rock, Arkansas	♦														♦									
Phoenix, Arizona	♦								♦		♦													
Tucson, Arizona	♦									♦							♦		♦		♦			
Bakersfield, California								♦							♦						♦	♦		
Concord, California	♦							♦					♦								♦			
Long Beach, California										♦								♦						
Los Angeles, California																		♦					♦	
Oakland, California																	♦		♦			♦		
Pasadena, California		♦						♦		♦		♦						♦						
Riverside, Claifornia	♦	♦																	♦					
Sacramento, California																				♦				♦
San Bernardino, California										♦														
San Diego, California																			♦					
San Jose, California														♦	♦			♦						
Santa Ana, California	♦																					♦		♦
Vallejo, California	♦													♦										
Aurora, Colorado													♦					♦						
Colorado Springs, Colorado						♦																		
Denver, Colorado						♦											♦			♦				
Bridgeport, Connecticut	♦											♦												
Hartford, Connecticut	♦																	♦						
New Haven, Connecticut								♦																
Stamford, Connecticut										♦		♦						♦				♦		
Waterbury, Connecticut																			♦					
Washington, DC								♦																♦
Wilmington, Delaware																		♦	♦					
Jacksonville, Florida											♦											♦		
Miami, Florida												♦												
Orlando, Florida	♦											♦						♦						
St. Petersburg, Florida						♦			♦															
Tampa, Florida											♦						♦	♦			♦			
Atlanta, Georgia	♦								♦									♦						
Savannah, Georgia									♦															♦
Agana, Guam										♦					♦									
Honolulu, Hawaii								♦																♦
Boise, Idaho																								♦
Chicago, Illinois								♦			♦													
Peoria, Illinois		♦																			♦			
Rockford, Illinois	♦														♦									
Springfield, Illinois									♦	♦														
Evansville, Indiana	♦																							
Indianapolis, Indiana	♦																							

1992

Urban Health Department Immunization Initiatives

	Initiatives to Improve the Immunization Delivery System						Initiatives to Expand Community Outreach and Public Awareness									Initiatives Involving Community Collaboration			Initiatives to Improve Immunization Documentation				
	Add days, hours, locations	Walk-in clinics	Reduce time to get appointments	Reduce waiting time during clinics	Increase personnel	Reduce missed opportunities	Target special populations	Immunize at public service sites	Immunize at community-based sites	Use mobile van units	Do mass immunization campaigns	Increase incentives to parents	Increase consumer education	Mass media campaigns	Creative advertising campaigns	Public-private sector task forces/coalitions	Partnerships with schools, community organizations and others	Maximize I-3 planning and development	Audits (day care, WIC, etc.)	Recall/reminder systems	Tracking systems	Stricter standard enforcement	Other
South Bend, Indiana							♦										♦					♦	
Cedar Rapids, Iowa	♦																						
Des Moines, Iowa							♦		♦									♦			♦		
Topeka, Kansas					♦												♦						
Lexington, Kentucky		♦																					
Louisville, Kentucky																			♦				♦
Baton Rouge, Louisiana	♦							♦															
New Orleans, Louisiana	♦	♦							♦		♦												
Shreveport, Louisiana	♦				♦									♦									
Portland, Maine						♦														♦			♦
Baltimore, Maryland							♦																
Boston, Massachusetts																		♦					
Ann Arbor, Michigan	♦													♦									
Detroit, Michigan	♦																			♦		♦	
Grand Rapids, Michigan	♦																						♦
Livonia, Michigan																							♦
Warren, Michigan								♦						♦									
Minneapolis, Minnesota							♦		♦											♦	♦		♦
St. Paul, Minnesota	♦								♦				♦										
Kansas City, Missouri		♦		♦		♦													♦	♦			
Springfield, Missouri																		♦					♦
Jackson, Mississippi		♦																					
Omaha, Nebraska	♦																♦						♦
Las Vegas, Nevada									♦											♦			
Reno, Nevada												♦											
Jersey City, New Jersey		♦						♦	♦					♦									
Newark, New Jersey													♦										
Paterson, New Jersey									♦														
Albuquerque, New Mexico	♦						♦																
Buffalo, New York	♦								♦														
New York City, New York	♦																						
Rochester, New York	♦						♦		♦			♦											
Syracuse, New York		♦					♦	♦									♦						
Yonkers, New York	♦																						
Charlotte, North Carolina	♦		♦																	♦			
Durham, North Carolina							♦							♦									
Greensboro, North Carolina																♦					♦		
Raleigh, North Carolina							♦		♦								♦						
Akron, Ohio																♦	♦						
Cincinnati, Ohio																				♦		♦	
Cleveland, Ohio																	♦					♦	
Columbus, Ohio					♦																		
Dayton, Ohio		♦							♦					♦									
Tulsa, Oklahoma	♦																♦						
Eugene, Oregon									♦								♦						♦

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1992

Urban Health Department Immunization Initiatives

	Initiatives to Improve the Immunization Delivery System							Initiatives to Expand Community Outreach and Public Awareness									Initiatives Involving Community Collaboration			Initiatives to Improve Immunization Documentation					
	Add days, hours, locations	Walk-in clinics	Reduce time to get appointments	Reduce waiting time during clinics	Increase personnel	Reduce missed opportunities		Target special populations	Immunize at public service sites	Immunize at community-based sites	Use mobile van units	Do mass immunization campaigns	Increase incentives to parents	Increase consumer education	Mass media campaigns	Creative advertising campaigns	Public-private sector task forces/coalitions	Partnerships with schools, community organizations and others	Maximize I-3 planning and development	Audits (day care, WIC, etc.)	Recall/reminder systems	Tracking systems	Stricter standard enforcement	Other
Portland, Oregon	♦																							
Allentown, Pennsylvania	♦																	♦				♦		
Erie, Pennsylvania																								
Philadelphia, Pennsylvania																		♦						
Pittsburgh, Pennsylvania											♦						♦							
San Juan, Puerto Rico		♦									♦						♦							
Columbia, South Carolina			♦		♦			♦							♦									
Sioux Falls, South Dakota	♦																				♦			
Chattanooga, Tennessee									♦															
Memphis, Tennessee									♦	♦												♦		
Nashville, Tennessee								♦		♦														
Amarillo, Texas													♦							♦	♦	♦		
Austin, Texas																					♦			
Corpus Christi, Texas								♦										♦						
Dallas, Texas	♦																	♦						
El Paso, Texas	♦	♦								♦						♦		♦						
Fort Worth, Texas	♦									♦	♦							♦						
Garland, Texas		♦	♦								♦													
Houston, Texas	♦												♦	♦										
Irving, Texas	♦																							
Laredo, Texas	♦							♦		♦														
Lubbock, Texas															♦									
Mesquite, Texas	♦																♦	♦		♦				
Pasadena, Texas										♦			♦											
San Antonio, Texas		♦						♦	♦	♦				♦	♦			♦						
Waco, Texas	♦							♦										♦					♦	
Salt Lake City, Utah																		♦					♦	
Burlington, Vermont																		♦				♦		
Alexandria, Virginia												♦	♦					♦			♦			
Chesapeake, Virginia	♦										♦								♦					
Newport News, Virginia									♦															
Norfolk, Virginia								♦	♦															
Portsmouth, Virginia								♦																
Richmond, Virginia	♦							♦										♦				♦		
Virginia Beach, Virginia								♦		♦													♦	
Seattle, Washington									♦												♦	♦		
Spokane, Washington																		♦					♦	
Tacoma, Washington														♦	♦		♦	♦						
Charleston, West Virginia	♦								♦										♦					
Madison, Wisconsin																	♦							
Milwaukee, Wisconsin		♦					♦	♦																
Cheyenne, Wyoming									♦															
																		♦						

Initiatives to Improve The Immunization Delivery System

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Initiatives to Improve The Immunization Delivery System

MOBILE, ALABAMA MOBILE COUNTY HEALTH DEPARTMENT	♦ Attempts to become more "user friendly;" improved staffing to decrease waiting time.
PHOENIX, ARIZONA MARICOPA COUNTY HEALTH DEPARTMENT (ALSO INCLUDES GLENDALE, MESA, SCOTTSDALE, TEMPE.)	♦ Establishment of community-based clinics on a regular monthly schedule. Clinics are scheduled for late afternoon and evening (3-7pm) to accommodate working families. Sites are chosen based on demographics, socioeconomic indicators, and disease incidence. We now have the capability of providing services in more isolated spots through use of a mobile public health clinic.
CONCORD, CALIFORNIA CONTRA COSTA COUNTY HEALTH SERVICES DEPARTMENT [1]	♦ Expanded clinic services.
RIVERSIDE, CALIFORNIA COUNTY OF RIVERSIDE HEALTH SERVICES AGENCY - DEPARTMENT OF PUBLIC HEALTH	♦ Making walk-in immunization services available at all health department clinic sites.
PASADENA, CALIFORNIA CITY OF PASADENA HEALTH DEPARTMENT	♦ Immediate access to immunizations through walk-in clinics. ♦ Child health appointments booked prior to delivery.

[1]This Health Department is located in Martinez, California.

- Increasing clinic hours, including evenings, during August and September.

SAN JOSE, CALIFORNIA
SANTA CLARA COUNTY HEALTH DEPARTMENT
(ALSO INCLUDES SUNNYVALE.)

- Established a new permanent MCH clinic in previously unserved southern portion of county to improve access.

SANTA ANA, CALIFORNIA
ORANGE COUNTY HEALTH CARE AGENCY
(ALSO INCLUDES ANAHEIM, FULLERTON, GARDEN GROVE, HUNTINGTON BEACH, IRVINE, AND ORANGE.)

- Improving immunization completion by fully immunizing children whenever they are in clinic setting.

COLORADO SPRINGS, COLORADO
EL PASO COUNTY DEPT. OF HEALTH AND ENVIRONMENT

- The most successful activity to improve childhood immunization levels this past year was carried out in our primary care clinics. Educational work with care providers about immunizing children whenever they are seen in a clinic and not using inappropriate contraindications has significantly decreased "provider error" as a reason for unimmunized children.

DENVER, COLORADO
DENVER DEPARTMENT OF HEALTH AND HOSPITALS

- Extension of clinic hours at all clinic sites and an increase in the number of immunization clinic days to include daily vaccine availability at all sites.

ORLANDO, FLORIDA
HRS/ORANGE COUNTY PUBLIC HEALTH UNIT

- Implementation of the missed opportunity recommendations from the state.

ST. PETERSBURG, FLORIDA
HRS/PINELLAS COUNTY PUBLIC HEALTH UNIT

HONOLULU, HAWAII
DEPARTMENT OF HEALTH - STATE OF HAWAII

- In 1991 the Department of Health Immunization Program began providing free Hepatitis B vaccine for infants. The vaccine is available free of charge for the first dose administered to infants prior to discharge from the hospital, and for the second and third doses administered by health care providers to indigent children less than one year of age.

BOISE, IDAHO
CENTRAL DISTRICT HEALTH DEPARTMENT

- We increased immunization activities after a measles epidemic. Immunization levels increased by 10% temporarily. For many people, the last time they were in the health department was for the pertussis outbreak 18 months before.

PEORIA, ILLINOIS
PEORIA CITY/COUNTY HEALTH DEPARTMENT

- Offer mix of walk-in clinics and appointments.

ROCKFORD, ILLINOIS
WINNEBAGO COUNTY PUBLIC HEALTH DEPARTMENT

- Increased number of satellite clinics; increased number of clinic hours at health department.

EVANSVILLE, INDIANA
VANDERBURGH COUNTY DEPARTMENT OF HEALTH

- Added a second monthly immunization clinic.

INDIANAPOLIS, INDIANA
MARION COUNTY HEALTH DEPARTMENT
(HEALTH AND HOSPITAL CORPORATION, INC.)

- Increased clinic hours in the health department facilities; extended clinic hours in the evening to make it more convenient for working families.

CEDAR RAPIDS, IOWA
LINN COUNTY HEALTH DEPARTMENT

- Offer immunization clinics two mornings per week year round.

♦ Transfer of nursing and clerical personnel into immunizations.	TOPEKA, KANSAS TOPEKA/SHAWNEE COUNTY HEALTH AGENCY
♦ Offer walk-in clinic days each week; offer complete walk-in days during school rush time.	LEXINGTON, KENTUCKY LEXINGTON-FAYETTE COUNTY HEALTH DEPARTMENT
♦ Offer immunizations every day and in a satellite clinic once a week; also give immunizations in child health-WIC clinics five days a week.	BATON ROUGE, LOUISIANA EAST BATON ROUGE PARISH HEALTH UNIT
♦ One of the largest maternal child health centers extended hours until 8pm three days each week to increase immunization accessibility. ♦ An LPN was hired for each of the seven maternal child health centers to provide "immunization on demand" clinics during regular clinic hours five days per week.	NEW ORLEANS, LOUISIANA CITY OF NEW ORLEANS HEALTH DEPARTMENT
♦ Providing extended hours at peak times to allow working parents to bring their children in for shots.	SHREVEPORT, LOUISIANA CADDO-SHREVEPORT HEALTH UNIT
♦ Protocol for giving vaccine to children with URI and OM. ♦ Offering second MMR to families with children over six years at cost (state does not supply MMR to children over six years if not first dose).	PORTLAND, MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES

BALTIMORE, MARYLAND BALTIMORE CITY HEALTH DEPARTMENT	♦ The "Immunization Only Clinic" has lowered the age for clinic attendance by a year; children as young as three years of age can now be immunized at this free clinic.
ANN ARBOR, MICHIGAN WASHTENAW COUNTY HUMAN SERVICES-PUBLIC HEALTH DIVISION [2]	♦ Clinics held at regular sites and times.
GRAND RAPIDS, MICHIGAN KENT COUNTY HEALTH DEPARTMENT	♦ Expanded hours at main clinic. ♦ Now offering second MMR.
LIVONIA, MICHIGAN WAYNE COUNTY DEPARTMENT OF PUBLIC HEALTH [3]	♦ We have managed to maintain our level of direct service provision and other immunization-related activities despite inflation driven cost increases and level or decreasing funding and revenues.
ST. PAUL, MINNESOTA ST. PAUL DIVISION OF PUBLIC HEALTH	♦ Hours of service at public health center clinic changed to provide more convenient times for clients to utilize services.

[2]This Health Department is located in Ypsilanti, Michigan.

[3]This Health Department is located in Westland, Michigan.

- Walk-in immunization clinics operating Monday through Friday with no appointments, physicals, or enrollment prerequisites. No charge for administration of vaccine. This clinic has a waiting time of less than 20 minutes except during peak school enrollment times.
- Adherence to true contraindication policy recommended by ACIP.

KANSAS CITY, MISSOURI
KANSAS CITY, MISSOURI HEALTH DEPARTMENT

- **Let's Invest Now in Kids (LINK) Clinic:** Started new clinic providing primary and preventive health care to Medicaid eligible children, especially those under age eight years.

SPRINGFIELD, MISSOURI
SPRINGFIELD-GREENE COUNTY PUBLIC HEALTH CENTER

- "Fast-Lane" clinics; integration of services.

JACKSON, MISSISSIPPI
HINDS COUNTY HEALTH DEPARTMENT

- Added one two-hour immunization clinic per week at the Douglas County Health Department allowing for increased opportunities for immunizations and decreased volume at other clinic sessions.

OMAHA, NEBRASKA
DOUGLAS COUNTY HEALTH DEPARTMENT

- Health Department offered clinics at non-traditional hours and places resulting in an over 27% increase in the number of doses administered by the department in 1991.

BUFFALO, NEW YORK
ERIE COUNTY HEALTH DEPARTMENT

NEW YORK CITY, NEW YORK NEW YORK CITY DEPARTMENT OF HEALTH	♦ A wide range of activities, including special outbreak control clinics, supplemented normal clinic operations. No single activity is thought to have improved immunization levels. No successful strategy has been devised to address the problem of under-immunization, particularly among preschool age children.
ROCHESTER, NEW YORK MONROE COUNTY DEPARTMENT OF HEALTH	♦ Addition of evening hours at central immunization clinic. Beginning July 1991, the health department immunization clinic held evening clinics. This enabled the clinic to be more responsive to working parents. ♦ Routine immunization of infants for Hepatitis B. Beginning July 1, 1992, all infants under one year of age offered routine immunization for Hepatitis B, in response to CDC and NYDOH recommendations. Information has been provided to area providers who will refer to the county health department clinic if they are unable to provide the vaccine.
SYRACUSE, NEW YORK ONONDAGA COUNTY HEALTH DEPARTMENT	♦ "Express-Lane" Immunization Only Clinics.
YONKERS, NEW YORK WESTCHESTER COUNTY DEPARTMENT OF HEALTH [1]	♦ Increased numbers of immunization clinics at department of health.

[1]This Health Department is located in Hawthorne, New York.

♦ Increased times and appointments for immunization clinics.	CHARLOTTE, NORTH CAROLINA MECKLENBURG COUNTY HEALTH DEPARTMENT
♦ Able to hire additional part-time nurses to work in overworked clinics.	COLUMBUS, OHIO COLUMBUS HEALTH DEPARTMENT
♦ Maintained a childhood immunization clinic offering all pediatric vaccines on a walk-in basis with service fees based on ability to pay.	DAYTON, OHIO COMBINED HEALTH DISTRICT OF MONTGOMERY COUNTY
♦ Extended evening clinics.	TULSA, OKLAHOMA TULSA CITY-COUNTY HEALTH DEPARTMENT
♦ Increased number of immunization clinics from one to four per month.	ALLENTOWN, PENNSYLVANIA ALLENTOWN HEALTH BUREAU
♦ Immunization services provided with no appointment needed (a no barrier to immunization instruction was also given).	SAN JUAN, PUERTO RICO SAN JUAN HEALTH DEPARTMENT [5]
♦ Appointment system for immunization with goal to accommodate every patient in a timely fashion; added additional staffing for immunizations.	COLUMBIA, SOUTH CAROLINA RICHLAND COUNTY HEALTH DISTRICT

[5] This Health Department is located in Rio Piedras, Puerto Rico.

SIOUX FALLS, SOUTH DAKOTA SIOUX RIVER VALLEY COMMUNITY HEALTH CENTER	♦ The Community Health Center has been having quarterly immunization clinics. They operate from 3:00pm to 8:30pm for any child in the area. If they have another family physician, we send the vaccines given and dates to that office for their records. This is a free clinic, we ask that they bring past immunization records with them if available. It has been quite successful for us.
EL PASO, TEXAS EL PASO CITY-COUNTY HEALTH AND ENVIRONMENT DIST.	♦ More walk-in clinics and more late hours clinics.
GARLAND, TEXAS GARLAND HEALTH DEPARTMENT	♦ Make appointments available within 14 days and taking some walk-ins.
HOUSTON, TEXAS CITY OF HOUSTON HEALTH AND HUMAN SERVICES	♦ Established weekday evening and Saturday immunization clinics for working parents to bring in children.
IRVING, TEXAS DEPARTMENT OF HEALTH SERVICES	♦ Extended hours of clinics two hours per week. Immunization clinic is heavily visited throughout the year, especially by children preparing for entry into elementary school or day care setting.
LAREDO, TEXAS CITY OF LAREDO HEALTH DEPARTMENT	♦ Evening clinics were instituted three evenings each week (Tuesday, Wednesday, and Thursday) from 5pm to 8pm. This has been extremely popular.
MESQUITE, TEXAS MESQUITE PUBLIC HEALTH CLINIC	♦ Offer Saturday shot clinics for back to school.

- De-centralized walk-in clinics; culturally sensitive staff; after hour coverage.

SAN ANTONIO, TEXAS
SAN ANTONIO METROPOLITAN HEALTH DISTRICT

- Expanded clinic hours in the month of August to accommodate increased number of clients seeking services.

WACO, TEXAS
WACO-McLENNAN COUNTY PUBLIC HEALTH DISTRICT

- Development of immunization action plan to increase clinic services.

CHESAPEAKE, VIRGINIA
CHESAPEAKE HEALTH DEPARTMENT

- **Comprehensive Health Improvement Project (CHIP):** Implemented project designed to provide a medical home (primary care) for children plus case management by public health nurses.
- Establishing immunization clinics in our clinic sites.

RICHMOND, VIRGINIA
RICHMOND CITY HEALTH DISTRICT

- The distribution system for free vaccines to clinic and private providers was made more user friendly to promote increased use. A 24 hour order line was added, as well as a FAX order number. Delivery within 5 days to their nearest health department site is guaranteed. A computerized invoicing system allows the department to keep better track of distribution and usage so shortages have not happened.

SEATTLE, WASHINGTON
SEATTLE-KING COUNTY DEPT. OF PUBLIC HEALTH

CHARLESTON, WEST VIRGINIA
KANAWHA-CHARLESTON HEALTH DEPARTMENT

- Available and accessible clinic opportunities for our clientele.

MILWAUKEE, WISCONSIN
CITY OF MILWAUKEE HEALTH DEPARTMENT

- Removal of access barriers within health department programs: avoiding inappropriate medical deferrals, availability of walk-in, no appointment, immunization-only appointments.

Initiatives to Expand Community Outreach and Public Awareness

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Initiatives to Expand Community Outreach and Public Awareness

BIRMINGHAM, ALABAMA JEFFERSON COUNTY DEPARTMENT OF HEALTH	♦ Marketing to the private sector.
MOBILE, ALABAMA MOBILE COUNTY HEALTH DEPARTMENT	♦ Improved educational efforts; EPSDT outreach.
PHOENIX, ARIZONA MARICOPA COUNTY HEALTH DEPARTMENT (ALSO INCLUDES GLENDALE, MESA, SCOTTSDALE AND TEMPE.)	♦ Piloting an immunization clinic in the waiting room of a busy AFDC Food Stamp Eligibility Office.
TUCSON, ARIZONA PIMA COUNTY HEALTH DEPARTMENT	♦ Held more clinics with extended hours. ♦ Increased number of on-site immunization clinics in schools.
LITTLE ROCK, ARKANSAS PULASKI COUNTY HEALTH DEPARTMENT - LITTLE ROCK CENTRAL	♦ Holding Saturday immunization clinics in all local health units which were well advertised by prominent citizens. ♦ Using lists generated by state immunization program to contact families to bring in children with delinquent immunizations for updates. ♦ Campaigning through the schools to promote adequate immunizations for all children.

- Advertising on television for immunization events; providing clinics in special areas or sites (going to community rather than community coming to the clinic).

BAKERSFIELD, CALIFORNIA
KERN COUNTY HEALTH DEPARTMENT

- Door-to-door outreach effort in "hard to reach" communities.
- Distribution of coupons for free immunization at immunization clinics to persons at or below 200% poverty. This was follow-up to discovery that cultural issues inhibit persons from requesting free services.

CONCORD, CALIFORNIA
CONTRA COSTA COUNTY HEALTH SERVICES DEPARTMENT [1]

- Department conducted intensive immunization efforts at a local park where 1200 children were immunized during the first two weeks of school.

LONG BEACH, CALIFORNIA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

- Outreach to summer lunch programs in community centers.
- Outreach to new parochial school students for immunizations.
- Outreach to community colleges to mass immunize college freshmen at risk.

PASADENA, CALIFORNIA
CITY OF PASADENA HEALTH DEPARTMENT

- Providing ongoing immunization services at two geographic locations that do not have a county clinic.

RIVERSIDE, CALIFORNIA
COUNTY OF RIVERSIDE HEALTH SERVICES AGENCY

[1]This Health Department is located in Martinez, California.

SACRAMENTO, CALIFORNIA SACRAMENTO COUNTY HEALTH DEPARTMENT	♦ Twelve special clinics for back-to-school assisted entering students in complying with school law requirements.
SAN BERNARDINO, CALIFORNIA SAN BERNARDINO COUNTY HEALTH DEPARTMENT (ALSO INCLUDES ONTARIO AND RANCHO CUCAMONGA.)	♦ Health fairs.
SAN JOSE, CALIFORNIA COUNTY OF SANTA CLARA HEALTH DEPARTMENT (ALSO INCLUDES SUNNYVALE.)	♦ Work with schools and day care centers to outreach and inform parents regarding immunizations. ♦ County-wide outreach to Medi-Cal families through social services mailout.
VALLEJO, CALIFORNIA SOLANO COUNTY HEALTH AND WELFARE SERVICES [2]	♦ Increasing immunization clinics in August and September to assure access for school entry. ♦ Forming the Immunization Advisory Group - this group informed the community about the problem of inadequate immunizations and increased the awareness of individuals about the need to address this issue.
AURORA, COLORADO TRI-COUNTY HEALTH DEPARTMENT [3]	♦ Offer of incentives to parents/kids.
BRIDGEPORT, CONNECTICUT CITY OF BRIDGEPORT HEALTH DEPARTMENT	♦ Free health clinics for immunizations and physical exams for new entrants in school system were offered 1/2 day weekly for five months; three mass immunization and physical exam clinics were offered during summer months for school entrants.

[2]This Health Department is located in Fairfield, California.

[3]This Health Department is located in Englewood, Colorado.

- Conducting immunization clinics for school-aged children.
- Maternal/child health outreach workers make home visits to prenatal clients and follow-up by stressing the importance of pediatric care.
- "Healthy Start Program" provides Medicaid liaison/case management and support services for prenatal and 0-6 year olds.

NEW HAVEN, CONNECTICUT
NEW HAVEN HEALTH DEPARTMENT

- A summer MMR clinicfest where over 1,000 vaccines were given during three sessions.
- Vaccine clinics in public schools.

STAMFORD, CONNECTICUT
STAMFORD HEALTH DEPARTMENT

- Use of volunteers.
- Highest official priority (mayor's commitment).
- Health department priority subdivisions: identifying high risk children.

WASHINGTON, DC
DEPARTMENT OF HUMAN SERVICES

- A large van with staff and facilities which goes to areas of greatest need.

JACKSONVILLE, FLORIDA
HRS/DUVAL COUNTY PUBLIC HEALTH UNIT

- Reached goal of providing immunizations to more than 5,000 children living in Dade County and providing 10,000 doses of vaccine during National Immunization Week. The week culminated with a very successful community outreach day. Immunization clinics were held at 23 locations throughout Dade County. 3,500 children were immunized with 6,000 doses of vaccine. The majority of them were children 0-5 years of age.

MIAMI, FLORIDA
HRS/DADE COUNTY HEALTH DEPARTMENT
(ALSO INCLUDES HIALEAH.)

ORLANDO, FLORIDA HRS/ORANGE COUNTY PUBLIC HEALTH UNIT	♦ Summer Immunizations - gave 2,204 immunizations over a period of six Saturdays during the summer.
ST. PETERSBURG, FLORIDA HRS/PINELLAS COUNTY PUBLIC HEALTH UNIT	♦ Immunizations given in child health clinics; immunizations to WIC referrals.
ATLANTA, GEORGIA FULTON COUNTY HEALTH DEPARTMENT	♦ Integration of immunization into WIC and other health department services where and when possible.
AGANA, GUAM DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES	♦ Conducted massive public awareness campaign including public education via electronic and written media and production of handouts and posters. This was linked with the public health nurses' vaccination campaign in the evenings and weekdays and at shopping centers during the weekends.
HONOLULU, HAWAII DEPARTMENT OF HEALTH - STATE OF HAWAII	♦ Public health nursing immunization clinics provide immunizations for infants and children in clinics located statewide. ♦ Special measles immunization clinics in April and May 1992 reached 10,000 persons statewide.
CHICAGO, ILLINOIS CHICAGO DEPARTMENT OF HEALTH	♦ Utilizing mobile vans in five public housing sites to deliver vaccine to a sub-optimally immunized population.
ROCKFORD, ILLINOIS WINNEBAGO COUNTY PUBLIC HEALTH DEPARTMENT	♦ Increased advertising.

♦ Offering immunizations while clients here for WIC. ♦ Offering immunizations in schools. ♦ Outreach.	SPRINGFIELD, ILLINOIS SPRINGFIELD DEPARTMENT OF PUBLIC HEALTH
♦ Special immunization clinics run at school opening.	SOUTH BEND, INDIANA ST. JOSEPH COUNTY HEALTH DEPARTMENT
♦ Hold clinic in Spanish-speaking center with interpreter.	DES MOINES, IOWA POLK COUNTY HEALTH DEPARTMENT
♦ Offer immunizations on Saturdays in WIC only clinics.	BATON ROUGE, LOUISIANA EAST BATON ROUGE PARISH HEALTH UNIT
♦ Immunization services offered at target school sites and health fairs. ♦ An immunization campaign was held during September and October at the Municipal Auditorium. At this site immunizations were given from 8am until 8pm five days a week over a two month span. 7,811 children were immunized.	NEW ORLEANS, LOUISIANA NEW ORLEANS HEALTH DEPARTMENT
♦ Advertising need for immunizations prior to kindergarten round-ups and providing extra staff for volumes.	SHREVEPORT, LOUISIANA CADDO-SHREVEPORT HEALTH UNIT
♦ Advertising.	ANN ARBOR, MICHIGAN WASHTENAW COUNTY HUMAN SERVICES PUBLIC HEALTH DIVISION [4]

[4]This Health Department is located in Ypsilanti, Michigan.

WARREN, MICHIGAN MACOMB COUNTY HEALTH DEPARTMENT [5]	♦ Focus on immunization in federal programs (WIC and EPSDT). ♦ Increased media utilization.
MINNEAPOLIS, MINNESOTA MINNEAPOLIS HEALTH DEPARTMENT	♦ School-based immunization clinics to provide second dose of MMR. ♦ Evaluation of immunization status at WIC clinics with subsequent referrals to appropriate providers.
ST. PAUL, MINNESOTA ST. PAUL PUBLIC HEALTH	♦ Putting immunization clinics in all WIC clinics. Educating on a one-on-one basis in these WIC clinics regarding the importance of immunizations.
LAS VEGAS, NEVADA CLARK COUNTY HEALTH DISTRICT	♦ Increased participation in community health fairs and at malls, schools, and community centers.
RENO, NEVADA WASHOE COUNTY DISTRICT HEALTH DEPARTMENT	♦ After a 1990 random study of WIC immunization levels revealed low baseline levels a coupon distribution system which could be redeemable in the outpatient clinic for immunizations was started. A repeat study completed in February of 1992 after starting the sytem showed WIC immunization levels rose dramatically.
JERSEY CITY, NEW JERSEY DEPARTMENT OF HUMAN RESOURCES - DIVISION OF HEALTH	♦ Over 1,000 more children received immunization services through Division of Health programs in 1991 compared to 1990 figures. A measles outbreak was also averted in 1991. These successes were achieved through media campaigns, participation in community health fairs, expansion and promotion of walk-in clinic hours, and an increased presence at the local WIC site.

[5] This Health Department is located in Mt. Clemens, Michigan.

- In the Spring of 1992 sponsored an educational campaign to inform Newark residents about measles and its complications. The volume of children actually immunized was low, but the parental response in terms of telephone calls and questions at the immunization sites was tremendous. Many children were receiving care from private physicians; those that were not, received the immunization if they met the necessary criteria.

NEWARK, NEW JERSEY
DIVISION OF COMMUNITY HEALTH

- Initiation of expanded outreach immunization program for city residents at various community sites during the months of April, May, and June of 1992 for the provision of preventable childhood disease immunizations.

PATTERSON, NEW JERSEY
PATTERSON DIVISION OF HEALTH

- Received grant from CDC for an immunization demonstration project in the Southwest quadrant of the city. This demonstration project provides for outreach, expanded hours including all day every weekday, some evenings and weekends, neighborhood clinics, and training WIC staff to read immunization records and make referrals.

ALBUQUERQUE, NEW MEXICO
BERNALILLO COUNTY HEALTH DEPARTMENT

- **Immunization Lottery** - a community initiative begun in April 1991 to target high risk preschoolers and encourage preventive medicine and well child visits. Children brought to participating physicians/health centers/clinics for immunizations have an opportunity to enter a monthly drawing for six cash prizes totalling $350 per month.

ROCHESTER, NEW YORK
MONROE COUNTY DEPARTMENT OF HEALTH

ROCHESTER, NEW YORK
(Continued from previous page)

- **Special community clinics in September:** Additional clinic sessions are held in community sites the first week of school to allow children entering school to be compliant with New York State immunization requirements for school entrance.

SYRACUSE, NEW YORK
ONONDAGA COUNTY HEALTH DEPARTMENT

- Co-location at WIC clinics - immunization, education, and literature given.
- Home visiting nurses educate families/monitor immunization status.

CHARLOTTE, NORTH CAROLINA
MECKLENBURG COUNTY HEALTH DEPARTMENT

- Offering community-based opportunities for education and immunizations at various sites.

DURHAM, NORTH CAROLINA
DURHAM COUNTY HEALTH DEPARTMENT

- Health director has done public service announcements on local television.
- Child service coordinators who work with at-risk infants/children have strongly promoted improved immunization status.

RALEIGH, NORTH CAROLINA
WAKE COUNTY DEPARTMENT OF HEALTH

- Increased EPSDT participation thereby increasing immunization rates.
- Outreach to public park (90 immunizations in two hours).

DAYTON, OHIO
COMBINED HEALTH DISTRICT OF MONTGOMERY COUNTY

- Promoted importance of vaccinations via TV/media.
- Offered childhood immunizations in homeless shelter (St. Vincent's Mission).

♦ Participated in "Due by Two" statewide program. ♦ Conduct special clinics with emphasis on immunizations.	TULSA, OKLAHOMA TULSA CITY-COUNTY HEALTH DEPARTMENT
♦ Holding more clinics in the schools using both school nurses and public health staff. ♦ Held clinics in the shopping malls in mid-August when all the stores were advertising back-to-school sales.	EUGENE, OREGON LANE COUNTY PUBLIC HEALTH SERVICES
♦ **21st Century and North Philadelphia Immunization Campaigns** - Volunteer Immunization Campaigns.	PHILADELPHIA, PENNSYLVANIA PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH
♦ **Immunization Festivals:** Mass immunization activities to update immunization to those children not adequately immunized. ♦ 24 hours measles immunization campaign at all Diagnostic and Treatment Centers during measles outbreak.	SAN JUAN, PUERTO RICO SAN JUAN HEALTH DEPARTMENT [6]
♦ Outreach clinic in housing project. ♦ Media advertising to increase patient awareness.	COLUMBIA, SOUTH CAROLINA RICHLAND COUNTY HEALTH DEPARTMENT
♦ Linking of immunizations with other public health services such as WIC.	CHATTANOOGA, TENNESSEE CHATTANOOGA-HAMILTON COUNTY HEALTH DEPARTMENT

[6]This Health Department is located in Rio Piedras, Puerto Rico.

MEMPHIS, TENNESSEE
MEMPHIS-SHELBY COUNTY HEALTH DEPARTMENT

- A Saturday in the mall was the most successful activity; plans are in process to establish a permanent mall immunization clinic.
- An immunization clinic part-time at the food distribution warehouse/WIC clinic is becoming successful; if the funding becomes available we will make this full-time and open another.

NASHVILLE, TENNESSEE
METROPOLITAN HEALTH DEPARTMENT

- Conducting outreach immunization clinics in public housing on a rotating basis.

AMARILLO, TEXAS
AMARILLO BI-CITY-COUNTY HEALTH DEPARTMENT

- Outreach education to mothers who deliver at local hospitals.

EL PASO, TEXAS
EL PASO CITY-COUNTY HEALTH AND ENVIRONMENT DISTRICT

- Expanding immunization outreach services.
- Distributing flyers at school to send home with children.
- Conducted public housing Saturday and Sunday clinics.

FORT WORTH, TEXAS
FORT WORTH-TARRANT COUNTY HEALTH DEPARTMENT

- Two immunization outreach teams travel to areas of highest needs; low income apartments, the malls and churches. Clinics are also held in the evening and on weekends.
- A week-long initiative held in three area malls in August in collaboration with Cooks-Fort Worth Children's Hospital, the Junior League, and area business leaders, immunizations are given from 10am to 6pm.

GARLAND, TEXAS
GARLAND HEALTH DEPARTMENT

- Participated in National Immunization Week in September 1991 and immunized over 100 children each evening between 4 and 7pm; however, the need was greater than could be met and another larger clinic that required no appointments was later held.

HOUSTON, TEXAS
HOUSTON HEALTH AND HUMAN SERVICES DEPARTMENT

- Use of an area Immunization Task Force Committee as a clearinghouse for all immunization activities and promoting education information for the public.
- Using public information office to advertise clinic locations through news media and promote special immunization activities.

LAREDO, TEXAS
CITY OF LAREDO HEALTH DEPARTMENT

- Outreach clinics are held at least monthly in an outlying neighborhood or school.

LUBBOCK, TEXAS
LUBBOCK HEALTH DEPARTMENT

- Flyers are given to prekindergarten students and parents.
- Immunization recommendations are placed in utility billing and on the placemat from McDonald's restaurants.

PASADENA, TEXAS
HARRIS COUNTY DEPARTMENT OF HEALTH

- Increased number of community-based sites.
- School-based immunization clinics.
- Distribution of immunization literature to parents to increase awareness.

SAN ANTONIO, TEXAS SAN ANTONIO METROPOLITAN HEALTH DISTRICT	♦ Special outreach clinics in hospitals, malls, and schools. ♦ Homebound programs in public housing. ♦ Promotion through schools and day cares; ongoing mass media campaign utilizing billboards, bus benches, and PSAs using prominent community leaders.
WACO, TEXAS WACO-McLENNAN COUNTY PUBLIC HEALTH DISTRICT	♦ **KinderSearch:** a local campaign to help indentify and vaccinate children entering into kindergarten. ♦ Utilized volunteers to provide services and as outreach workers to disseminate information.
ALEXANDRIA, VIRGINIA ALEXANDRIA HEALTH DEPARTMENT	♦ Involvement in a metropolitan campaign of community education and client awards for completion of immunization at appropriate ages.
CHESAPEAKE, VIRGINIA CHESAPEAKE HEALTH DEPARTMENT	♦ Acquisition of mobile clinic to deliver immunization services to underserved areas.
NORFOLK, VIRGINIA NORFOLK DEPARTMENT OF PUBLIC HEALTH	♦ School clinics to administer second measles requirement to all fifth graders. ♦ Special clinics in WIC areas. ♦ Off-site immunization clinics in public housing areas.

[1] This Health Department is located in Houston, Texas

- Day care seminar - workshop on immunizations.

RICHMOND, VIRGINIA
RICHMOND CITY HEALTH DEPARTMENT

- School-based immunization clinic to administer second MMR to all fifth graders (4500 administered).
- Special clinics and longer clinics to administer immunizations to enrolling kindergartners.

VIRGINIA BEACH, VIRGINIA
VIRGINIA BEACH HEALTH DISTRICT

- Billboards jointly sponsored by Junior League of Spokane; publishing immunization schedules in newspapers; water bill inserts; radio and TV spot announcements; and articles in community center newsletters.
- Direct mailing with requirements and clinic schedules to day care centers and local grade schools.
- Sixth grade poster contest regarding MMR booster.

SPOKANE, WASHINGTON
SPOKANE COUNTY HEALTH DISTRICT

- School clinics.

TACOMA, WASHINGTON
TACOMA-PIERCE COUNTY HEALTH DEPARTMENT

- Head Start round-up of applicants and their siblings.
- Birth certificates reviewed and materials describing immunization clinic sent to families in need.

MADISON, WISCONSIN
MADISON DEPARTMENT OF PUBLIC HEALTH

- Use of Health Department run WIC sites to provide immunizations.

MILWAUKEE, WISCONSIN
MILWAUKEE HEALTH DEPARTMENT

Initiatives to Build Community Collaborations and Coalitions

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Initiatives Involving Community Collaborations and Coalitions

TUCSON, ARIZONA
PIMA COUNTY HEALTH DEPARTMENT

- Held community focus group sessions to discuss problems, issues, and solutions regarding immunizations.
- Developed and submitted Immunization Action Plan to state for additional funding.

LONG BEACH, CALIFORNIA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

- The Long Beach Unified School District and the City Health Department combined resources to increase accessibility of immunization services during the fall "Back-to-School" time. The Department provided vaccines, supplies and technical assistance. School nurses administered vaccines at selected schools. 200 additional children were vaccinated through this cooperative effort.

LOS ANGELES, CALIFORNIA
LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
(ALSO INCLUDES EL MONTE, GLENDALE, INGLEWOOD, POMONA, AND TORRANCE.)

- As a result of the county's measles epidemic during the past four years, the department has formed many new partnerships with health-related and non-health organizations which should have a positive impact on improving childhood immunization levels in the future.

♦ Formation of county-wide task force of public and private medical providers, community residents, and community-based organizations. ♦ Development of a comprehensive Immunization Action Plan.	OAKLAND, CALIFORNIA ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY (ALSO INCLUDES FREMONT AND HAYWARD.)
♦ Joint networking with community volunteer agencies (i.e., the Junior League, Red Cross) to facilitate mass immunization clinics in the fall.	PASADENA, CALIFORNIA CITY OF PASADENA HEALTH DEPARTMENT
♦ Sponsoring community meeting to elicit support from private agencies in applying for grant funding.	RIVERSIDE, CALIFORNIA COUNTY OF RIVERSIDE HEALTH SERVICES AGENCY
♦ Planning process involved in Infant Immunization Initiative Plan was most successful activity. Brought together the community leaders to discuss the problem, brainstorm about possible solutions and develop a plan of action to implement over the next few years to meet the goal that all children in our community will be fully immunized by age two years.	SAN DIEGO, CALIFORNIA COUNTY OF SAN DIEGO DEPARTMENT OF HEALTH SERVICES (ALSO INCLUDES CHULA VISTA, ESCONDIDO, AND OCEANSIDE.)
♦ Provide schools and community clinics with state supplied vaccine. ♦ Collaboration with other non-government agencies in media campaign.	SAN JOSE, CALIFORNIA COUNTY OF SANTA CLARA HEALTH DEPARTMENT (ALSO INCLUDES SUNNYVALE.)
♦ County sponsorship of state legislation to require all health insurers in state to provide full coverage for childhood immunizations.	SANTA ANA, CALIFORNIA ORANGE COUNTY HEALTH CARE AGENCY (ALSO INCLUDES ANAHEIM, FULLERTON, GARDEN GROVE, HUNTINGTON BEACH, IRVINE, AND ORANGE.)

AURORA, COLORADO TRI-COUNTY HEALTH DEPARTMENT [1]	♦ Collaboration with Rotary Clubs.
DENVER, COLORADO DENVER DEPARTMENT OF HEALTH AND HOSPITALS	♦ The most promising activities of the health department have been in collaborative work with other public and private providers to develop a statewide Immunization Coalition. This Coalition has been working to develop an action plan to improve statewide immunization levels among preschoolers. Activities are in three areas: legislative, provider practices and education, and patient education.
HARTFORD, CONNECTICUT HARTFORD HEALTH DEPARTMENT	♦ The health department convened all primary caregivers to work together on a publicized immunization day. Turn out was not great but working together sharing problems and solutions has increased awareness of the scope of the problem. Clinics are now about to expand hours.
STAMFORD, CONNECTICUT STAMFORD HEALTH DEPARTMENT	♦ Improved interagency relationships between WIC and public health nursing.
WATERBURY, CONNECTICUT WATERBURY DEPARTMENT OF PUBLIC HEALTH	♦ Cooperated with state health department in application for Infant Immunization Initiative that will target children under two years.
WASHINGTON, DC DEPARTMENT OF HUMAN SERVICES	♦ Increased cooperation of other agencies.

[1]This Health Department is located in Englewood, Colorado.

- Cooperative Immunization Action Plan.
- Integration with WIC to provide delinquency status on WIC system and provision of nurse to provide immunization.

WILMINGTON, DELAWARE
DELAWARE DIVISION OF PUBLIC HEALTH

- Participation in a joint effort with Florida Nurses' Association (FNA) to sponsor an immunization health fair at a Head Start center located in an 800 family apartment complex.

ORLANDO, FLORIDA
HRS/ORANGE COUNTY PUBLIC HEALTH UNIT

- Establishment of a county-wide Immunization Task Force in January 1992.
- "Be Wise Immunize" partnership with the Kiwanis Club of Tampa, St. Joseph's Hospital, Tampa Housing Authority, and the Hillsborough County Public Health Unit. A mobile van goes into the housing project to administer immunizations monthly.
- Cooperating with the WIC program to give out reminder notices.

TAMPA, FLORIDA
HRS/HILLSBOROUGH COUNTY PUBLIC HEALTH UNIT

- Beginning of program with the Scottish-Rite Hospital to provide evening immunization clinics in eight of our 20 sites once a week and Saturday immunization clinics at four sites.

ATLANTA, GEORGIA
FULTON COUNTY HEALTH DEPARTMENT

- Partial integration of immunization and WIC programs.

SAVANNAH, GEORGIA
CHATHAM COUNTY HEALTH DEPARTMENT

DES MOINES, IOWA POLK COUNTY HEALTH DEPARTMENT	♦ Participated in I-3 and Robert Wood Johnson applications.
TOPEKA, KANSAS TOPEKA-SHAWNEE COUNTY HEALTH AGENCY	♦ Start of community program with the hospitals and schools to take immunizations to the children. ♦ Coordination of immunizations with other child health programs.
BOSTON, MASSACHUSETTS DEPARTMENT OF HEALTH AND HOSPITALS	♦ **Boston Immunization Action Plan (BIAP):** Functioned as lead agency to bring together agencies/groups representing community health centers, hospitals, private practitioners, universities, housing groups, church groups, and other community-based agencies to submit application for Infant Immunization Initiative (I-3). 64 different programs/agencies from both the public and private sectors collaborated to develop BIAP that addresses the challenge of improving immunization of all children in Boston. The planning phase of the BIAP made the participants more aware of the problem of low immunization levels, what they can do, and helped to identify and form new linkages/partnerships.
DETROIT, MICHIGAN DETROIT HEALTH DEPARTMENT	♦ Submitted I-3 Plan to CDC and initial seed money has been awarded.
MINNEAPOLIS, MINNESOTA MINNEAPOLIS HEALTH DEPARTMENT	♦ Helped to pass state legislation making it possible to share immunization information about parental release of information consent to providers of immunization services.

- Participating with community leaders in a grant application to address the problems and achieve goals regarding the immunization status of preschool children.

SPRINGFIELD, MISSOURI
SPRINGFIELD-GREENE COUNTY PUBLIC HEALTH CENTER

- Collaboration with the Indian Chicano Health Center to provide immunizations through that facility.

OMAHA, NEBRASKA
DOUGLAS COUNTY HEALTH DEPARTMENT

- Inservice of DSS staff to increase immunization awareness, set up referral mechanism.
- Linkage with community agencies such as Junior League to plan education media campaign regarding immunization.

SYRACUSE, NEW YORK
ONONDAGA COUNTY HEALTH DEPARTMENT

- Direct contact with school (including preschool) by phone, mail.

YONKERS, NEW YORK
WESTCHESTER COUNTY DEPARTMENT OF HEALTH [2]

- **Immunization Task Force:** Private pediatricians, civic groups, and other community folks have joined the Health Department in attempting to address low levels of childhood immunization. The Task Force has been working on two projects: 1) an immunization registry designed to track all children in Guilford County to ensure age-appropriate immunizations; and 2) off-site (in areas where children are likely to be inadequately immunized, i.e. housing projects) immunization clinics with door prizes and refreshments as incentives for parents to bring children in for shots. The effort to establish a registry was put into a grant proposal which is currently in the second stage of review. The initial off-site clinics were poorly attended but they are being evaluated to assess what needs to be changed.

GREENSBORO, NORTH CAROLINA
GUILFORD COUNTY DEPARTMENT OF PUBLIC HEALTH

[2] This Health Department is located in Hawthorne, New York.

RALEIGH, NORTH CAROLINA WAKE COUNTY DEPARTMENT OF HEALTH	♦ Joint awareness campaign with Junior League.
AKRON, OHIO AKRON HEALTH DEPARTMENT	♦ Have formed a strong coalition between the local Children's Hospital, OB staff at adult hospitals, local health departments, and Junior League to develop a concentrated and long term program to increase immunizations. Plans are in progress to have immunization data readily accessible via computer to all coalition health care providers to facilitate timely administration and decrease missed opportunities.
CLEVELAND, OHIO CLEVELAND DEPARTMENT OF PUBLIC HEALTH	♦ Provision of vaccines to nine quasi-public clinics for increased vaccine availability. This includes hospital outpatient departments and neighborhood clinics.
TULSA, OKLAHOMA TULSA CITY-COUNTY HEALTH DEPARTMENT	♦ **"Be Wise - Immunize:"** Two month campaign in Spring 1991, with Tulsa Southwest Rotary Club and Junior League in Tulsa.
EUGENE, OREGON WAYNE COUNTY PUBLIC HEALTH SERVICES	♦ Have assigned one staff person - a community service worker - to work with day care and Head Start staff in understanding the Oregon School - Day Care Immunization Law.
PORTLAND, OREGON MULTNOMAH COUNTY HEALTH DIVISION	♦ Working with community groups such as clubs, churches, etc. to increase availability of special clinics held in evenings and or Saturdays to improve accessibility of vaccine.

- Cooperating with two local hospitals, one skilled nursing agency, and one minority health agency to provide additional free immunization services in the city and county. Erie County Department of Health provides vaccine and the other four agencies provide the staff to service clients following health department protocols.

ERIE, PENNSYLVANIA
ERIE COUNTY DEPARTMENT OF HEALTH

- Development of a coalition of over 65 health and service providers in community-based organizations to improve immunization levels.

PHILADELPHIA, PENNSYLVANIA
PHILADELPHIA DEPARTMENT OF PUBLIC HEALTH

- Based on ACIP's recommendation regarding a second dose of MMR vaccine, the health department sent a letter to all school superintendents and principals in the county requesting that parents be so informed. Most school districts complied with the request, generating many vaccine requests. Special immunization clinics were arranged and more than 2,000 doses were administered during June and July.

PITTSBURGH, PENNSYLVANIA
ALLEGHENY DEPARTMENT OF PUBLIC HEALTH

- WIC involvement in immunizing patients already on health department program.
- Adding immunization reminder to WIC TIC.

COLUMBIA, SOUTH CAROLINA
RICHLAND COUNTY HEALTH DEPARTMENT

AUSTIN, TEXAS
CITY OF AUSTIN HHSD-TRAVIS COUNTY HEALTH DEPARTMENT

- Over the last two years the department has worked closely with community-based organizations to provide biologicals to the agencies at no cost to increase access. This effort has greatly improved access to services along with interaction with community-based organizations.

CORPUS CHRISTI, TEXAS
CORPUS CHRISTI-NUECES COUNTY PUBLIC HEALTH DISTRICT

- A survey was done in the project office immunization clinic to determine the census tracts with the lowest immunization levels of preschool age children. The Junior League then printed and distributed simple pamphlets in the target areas. PSAs were also shown. The Junior League phone bank contacted about 2,000 households in the census tracts to remind parents to have children immunized. Approximately 600 responses to the calls occurred.

DALLAS, TEXAS
DALLAS DEPARTMENT OF HEALTH AND HUMAN SERVICES

- The most successful efforts combined multiple agency efforts, expanded service hours and outreach efforts which involved residents of the community.

MESQUITE, TEXAS
MESQUITE PUBLIC HEALTH CLINIC

- Health clinic interaction with the local independent school district's nursing facility.
- A Child Action Initiative Co-op effort.

- Coordinated efforts with AFDC and WIC to provide immunizations on site.
- Permanent immunization clinics in hospitals and community health centers.
- 60% of EPSDT providers provide immunizations.
- Working with business, private community and volunteer organizations.

SAN ANTONIO, TEXAS
SAN ANTONIO METROPOLITAN HEALTH DISTRICT

- **"Don't Wait to Vaccinate:"** Collaborated with Junior League in campaign to inform parents on the importance of vaccinations.

WACO, TEXAS
WACO-McLENNAN COUNTY PUBLIC HEALTH DISTRICT

- The health department has five community health districts that provide medical care, WIC and immunization services. WIC technicians check immunization status of participants and provide free immunization vouchers/waivers for those who cannot pay nominal health department fee.

SALT LAKE CITY, UTAH
SALT LAKE CITY-COUNTY HEALTH DEPARTMENT

- Working more closely with private providers to assist in following up on those overdue for immunizations.

BURLINGTON, VERMONT
VERMONT STATE DEPARTMENT OF HEALTH

- Initiation of a limited immunization recall program using volunteers from the Kiwanis Club.

ALEXANDRIA, VIRGINIA
ALEXANDRIA HEALTH DEPARTMENT

- In the future we hope to be a recipient of a Robert Wood Johnson Foundation All Kids Count Grant for "All Kids Covered."

NEWPORT NEWS, VIRGINIA
PENINSULA HEALTH DEPARTMENT

- Networking with schools to provide second dose MMR to school entrants and sixth graders.

RICHMOND, VIRGINIA
RICHMOND CITY HEALTH DEPARTMENT

SEATTLE, WASHINGTON SEATTLE-KING COUNTY DEPARTMENT OF PUBLIC HEALTH	♦ Health department worked with school districts in the county to assure that fifth grade students received their second dose MMR prior to entry into the sixth grade in response to a change in the state immunization plan. Clinics were held in schools in 10 districts. Local hospitals held special "Measles Clinics" with free or very low cost immunizations offered. Community health clinics and several hospital-based primary care clinics offered "express lane" services to kids there to receive immunizations only.
SPOKANE, WASHINGTON SPOKANE COUNTY HEALTH DEPARTMENT	♦ Billboards jointly sponsored by Junior League of Spokane.
TACOMA, WASHINGTON TACOMA-PIERCE COUNTY HEALTH DEPARTMENT	♦ The Infant Immunization Initiative brought members of the community together - health, physician, and service groups. The group identified barriers and strategies to address these as a community.
MILWAUKEE, WISCONSIN MILWAUKEE HEALTH DEPARTMENT	♦ Creation of an Immunization Task Force to guide program efforts and grant applications. ♦ Involvement of community-based immunization providers in efforts.
CHEYENNE, WYOMING CHEYENNE CITY-LARAMIE COUNTY HEALTH DEPARTMENT	♦ Networked with the school nurses to immunize all current seventh graders (1991-1992 school year) and also the current sixth graders with a second dose of MMR. State law now requires that all seventh graders (1992-1993 school year) have proof of a second MMR.

Initiatives to Improve Immunization Documentation

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Initiatives to Improve Immunization Documentation

BIRMINGHAM, ALABAMA JEFFERSON COUNTY DEPARTMENT OF HEALTH	♦ Day care audits and education.
MOBILE, ALABAMA MOBILE COUNTY HEALTH DEPARTMENT	♦ More timely delinquent recall.
ANCHORAGE, ALASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES	♦ Started to input immunization data into the RPMS. This will facilitate a tracking system.
TUCSON, ARIZONA PIMA COUNTY HEALTH DEPARTMENT	♦ Implemented postcard reminder system.
BAKERSFIELD, CALIFORNIA KERN COUNTY HEALTH DEPARTMENT	♦ Tracking infants through birth certificate data. Mailing reminders at six weeks to parents of newborns.
CONCORD, CALIFORNIA CONTRA COSTA HEALTH SERVICES [1]	♦ Continuation of a reminder system and computerized record keeping system.
LOS ANGELES, CALIFORNIA LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES (ALSO INCLUDES EL MONTE, GLENDALE, INGLEWOOD, POMONA, AND TORRANCE.)	♦ Historically, the most successful activity to improve childhood immunization levels has been the enforcement of the state immunization law for children attending preschool facilities and schools.

[1]This Health Department is located in Martinez, California.

♦ Submission of RWJ grant for development of immunization registry.	OAKLAND, CALIFORNIA ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY (ALSO INCLUDES FREMONT AND HAYWARD.)
♦ School review and audits helped enforcement of school immunization law and increased immunization levels in school-age population.	SACRAMENTO, CALIFORNIA SACRAMENTO COUNTY HEALTH DEPARTMENT
♦ Application for "All Kids Count" funding to establish a comprehensive county-wide immunization data base for monitoring and follow-up.	SANTA ANA, CALIFORNIA ORANGE COUNTY HEALTH CARE AGENCY (ALSO INCLUDES ANAHEIM, FULLERTON, GARDEN GROVE, HUNTINGTON BEACH, IRVINE AND ORANGE.)
♦ Ongoing audits to identify percentages of fully immunized preschoolers and reasons for deficient immunizations.	DENVER, COLORADO DENVER DEPARTMENT OF HEALTH AND HOSPITALS
♦ Development of a computer program to track families. This formed the Master's thesis for a Yale student who has now graduated.	STAMFORD, CONNECTICUT STAMFORD HEALTH DEPARTMENT
♦ Not yet completed, but a computerized registry for tracking by any provider county-wide; with reference to what, when, and where.	JACKSONVILLE, FLORIDA HRS/DUVAL COUNTY PUBLIC HEALTH UNIT
♦ Participation in a pilot study to determine the effect of the use of children's immunization. Response to the autodialer was 70% while card response was 15%.	SAVANNAH, GEORGIA CHATHAM COUNTY HEALTH DEPARTMENT
♦ Computerized reminder card sent after one month lapse.	PEORIA, ILLINOIS PEORIA CITY/COUNTY HEALTH DEPARTMENT

SOUTH BEND, INDIANA ST. JOSEPH COUNTY HEALTH DEPARTMENT	♦ Cooperation with school systems to assure full compliance with state law at beginning of each year.
DES MOINES, IOWA POLK COUNTY HEALTH DEPARTMENT	♦ Explored computer tracking.
LOUISVILLE, KENTUCKY LOUISVILLE-JEFFERSON COUNTY HEALTH DEPARTMENT	♦ Response to measles outbreak resulted in increased awareness of the need for and benefits of immunization. Day cares, preschools, schools and colleges increased the emphasis on immunizations as a criteria for attending. Mass review of immunization records in schools and other groups to identify persons needing additional doses of recommended/required vaccines.
PORTLAND, MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES - PUBLIC HEALTH DIVISION	♦ Aggressive, labor intensive recall system.
DETROIT, MICHIGAN DETROIT HEALTH DEPARTMENT	♦ Enforcement of state law for new school entrants: 9,000-10,000 exclusion notices issued during three exclusion periods; Detroit Health Department had special immunization clinics at the nine primary care centers during exclusion periods. Ongoing weekly immunization clinics are also scheduled throughout the year. ♦ Computerized follow-up letters to all children (including those not enrolled in health department primary care) who have incomplete immunizations. ♦ Surveying for monitoring missed appointments.

♦ Public health nurses evaluated day care records for adequacy of immunizations and initiated "catch up" protocols. ♦ Initiated research on immunization tracking systems with the Minnesota Department of Health.	MINNEAPOLIS, MINNESOTA MINNEAPOLIS HEALTH DEPARTMENT
♦ Maintenance of a recall file to contact parents that do not return at the appropriate time. ♦ Computerized day care audits of 100% of the licensed day care center immunization records.	KANSAS CITY, MISSOURI KANSAS CITY, MISSOURI HEALTH DEPARTMENT
♦ Implementation of a study to define age-appropriate immunization levels of preschool population (kindergarten retrospective study).	OMAHA, NEBRASKA DOUGLAS COUNTY HEALTH DEPARTMENT
♦ Reminder/recall postcard system was implemented again last year. Two year immunization rate went from 46% to 59%. Had discontinued the postcard reminder system in 1988 and two year immunization rate had fallen from 64% to 46%.	LAS VEGAS, NEVADA CLARK COUNTY HEALTH DISTRICT
♦ Reminder letters for appointments.	CHARLOTTE, NORTH CAROLINA MECKLENBURG COUNTY HEALTH DEPARTMENT
♦ Timely follow-up for missed appointments. ♦ Immunization clinics coupled with school expulsions.	CINCINNATI, OHIO CINCINNATI HEALTH DEPARTMENT

CLEVELAND, OHIO CLEVELAND DEPARTMENT OF PUBLIC HEALTH	♦ Cooperation with local schools to enforce immunization requirements.
PORTLAND, OREGON MULTNOMAH COUNTY HEALTH DIVISION	♦ The Health Department has been working on improving monitoring and tracking system for children under the age of two by being allowed to enter dates of vaccines received at other delivery systems in our computer so records are more complete and comparing computer printout, chart, and personal record of each child when they come in for immunizations to make sure that all dates are correctly documented and the correct number of doses of vaccine are more accurately provided.
COLUMBIA, SOUTH CAROLINA RICHLAND COUNTY HEALTH DEPARTMENT	♦ Sending immunization reminders by mail to delinquents.
CHATTANOOGA, TENNESSEE CHATTANOOGA-HAMILTON COUNTY HEALTH DEPARTMENT	♦ Computer tracking of vaccine-delinquent children.
NASHVILLE, TENNESSEE MEMPHIS-SHELBY COUNTY HEALTH DEPARTMENT	♦ Establishment of an RN position to investigate and provide follow-up to any child found to be delinquent on immunizations. She receives referrals from health department clinics, subcontracting clinics, and from data obtained from day care and school audits. ♦ Ongoing program in conjunction with Department of Human Services to audit all day care programs (licensed) for immunization status of their attendees. ♦ Recently started a tracking and recall system for immunizations using birth certificate data.

♦ Recall system - sending lapsed reminders.	AMARILLO, TEXAS AMARILLO BI-CITY-COUNTY HEALTH DEPARTMENT
♦ Day care center audits.	PASADENA, TEXAS HARRIS COUNTY DEPARTMENT OF HEALTH [2]
♦ Hook up with Medicaid claims information as another way to track Medicaid children who may be overdue for immunizations.	BURLINGTON, VERMONT VERMONT DEPARTMENT OF HEALTH
♦ Computerized program to identify children who have not come back for immunizations. ♦ Submission of Robert Wood Johnson grant for tracking immunization in children from birth to school age. ♦ Continue with high priority infant tracking program for at-risk developmentally delayed children.	PORTSMOUTH, VIRGINIA PORTSMOUTH DEPARTMENT OF HEALTH
♦ Maintaining tracking and recall system for all children receiving immunizations in health department.	VIRGINIA BEACH, VIRGINIA VIRGINIA BEACH HEALTH DISTRICT

[2] This Health Department is located in Houston, Texas.

DIRECTORY OF URBAN MCH PROGRAMS AND LEADERSHIP

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Directory of Urban MCH Programs and Leadership

In the 1990 edition of *What Works*, CityMatCH compiled its first Directory of Urban MCH Programs and Directors. In an effort to continue to facilitate communication and collaboration among urban MCH leaders and their colleagues in other public and private spheres, the directory has been updated and expanded; updated to reflect changes in the information on the largest urban health departments presented in the first directory, and expanded to include information on smaller urban health departments (those serving cities with populations between 100,000 and 200,000).

The information in this directory has been gathered from several sources, primarily the 1992 Survey of Maternal and Child Health In Urban Health Departments and CityMatCH membership information. The name and title of each health department's designated MCH director or coordinator are presented along with the health department's name, address, and telephone and fax numbers. A few health departments report that no one person is designated MCH director (these are noted with an asterisk). The name of an MCH contact person is provided for those health departments where no single individual is designated as the MCH director.

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Kanawha-Charleston Health Dept.
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Charleston, WV 25323
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Fax: 304/348-6821

CHEYENNE, WY
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Cheyenne City-Laramie Co. Health Dept.
100 Central Avenue
Cheyenne, WY 82007
Phone: 307/633-4000

*No one person is MCH director.

APPENDICES

APPENDIX A

Maternal and Child Health in Urban Health Departments in the United States
1992 Focus: Immunizations

A Follow-up Survey of CityMatCH
Spring 1992

This survey is about your health department's initiatives to improve the health of families and children. In 1989 and 1990, CityMatCH collected basic information about the organization, mandate, successes and constraints of urban maternal and child health (MCH) programs through a survey of major city and county health departments. Results of these surveys were published and distributed in the Fall of 1989 as the Resource Directory of Major Urban MCH Programs and in the Fall of 1990 as What Works: 1990 Urban MCH Programs. Urban MCH program leaders continue to express the need to know more about successful and innovative programs in other cities and counties.

The survey is to be filled out by the person who is most knowledgeable about your health department's maternal and child health activities. Even if you are unable to answer some questions, please return the questionnaire.

The survey has two parts.
Part 1 is an update of information provided by health departments in the 1990 survey. **Attached please find a sheet summarizing your health department's previous responses to several of the questions in Part 1.** (If your health department did not participate in the 1990 survey, a summary sheet is not attached.) Update or correct the 1990 data as necessary on this questionnaire form.

Part 2 asks for information about childhood immunizations. Responses will be shared among urban MCH programs so that you and other urban health departments can learn about other successful local MCH efforts nationwide which target vaccine preventable conditions of childhood.

A self addressed envelope is provided. Please attach any additional materials you believe will facilitate your responses to the questions. If you have any questions about this survey, please contact Dr. Magda Peck at 402-559-8323 (FAX: 402-559-5355). **Thank you for your participation.**

PLEASE RETURN THE SURVEY BY JUNE 26, 1992 TO: CityMatCH at the
Department of Pediatrics
University of Nebraska Medical Center
600 South 42nd Street
Omaha, NE 68198-2167

Jurisdiction: City _____ **State** _____
Count(ies) [if applicable] _____
Official Title of Health Department: _____

Name of person who completed the questionnaire and can answer questions about it:
Name: _____
Position: _____
Address: _____
_____
City: _____ State: _____ Zip: _____
Telephone: _____ FAX: _____

DATE COMPLETED: _____

PART 1: UPDATE OF CITYMATCH DATABASE

Please answer all of the questions below. Some of the information requested below was provided by someone in your health department last year in response to the 1990 City**MatCH** Survey of Maternal and Child Health in Major Urban Health Departments. **Review the enclosed information sheet which summarizes some of your health department's responses to that survey.** Please provide corrected or new information below as applicable.

1. Is the organizational structure of maternal and child health programs and activities in your health department the same now as it was in 1990? (X one)

_____ yes _____ no _____ don't know

Please attach your health department's most recent organizational chart.

2. MCH Leadership

A. Who in your health department is considered the director or coordinator of Maternal and Child Health?

___ the same person as in 1990 survey (mark any changes/updates below)
___ a different person from 1990 survey (please update below)
___ this is our health department's first survey (complete all items below)
___ no one person is MCH director (skip to Question #3)

Name: _____
Position: _____
Address: _____
_____
City: _____ State: _____ Zip: _____
Telephone: _____ FAX: _____

B. Additional information about the MCH director or coordinator:

1. His/her position is: ____ full-time ____ part-time
2. Number of years as MCH Director or Coordinator: ____ years
3. His/her professional degree(s): (X all that apply)
   - ____ MD Specialty: _____
   - ____ MPA
   - ____ MPH
   - ____ RN
   - ____ MSW
   - ____ DSc, DrPH, PhD
   - ____ MSN
   - Other (please specify): _____
4. Sex: ____ Female ____ Male
5. His/her age group: (X one)
   - ____ 20-29 ____ 40-49 ____ 60-69
   - ____ 30-39 ____ 50-59 ____ 70 and over

6a. Race:
- ____ White
- ____ Black/African American
- ____ Native American, Eskimo, Aleut
- ____ Asian or Pacific Islander
- ____ Other race: _____

6b. Ethnicity:
- ____ Not of Hispanic Origin
- ____ Hispanic/Latino
- ____ Mexican
- ____ Puerto Rican
- ____ Cuban
- ____ Other Hispanic: _____

3. Fiscal Resources for MCH

A. Budget

1. What is your health department's total operating budget for FY92? (Give amount in dollars)
   $ _____ OR (X one): ____ unknown ____ not available

2. Please estimate: What proportion of your health department's total operating budget for FY92 is dedicated to maternal and child health activities?
   _____% OR (X one): ____ unknown ____ not available

3. How did the MCH budget in your health department change between FY91 and FY92?
   ____ increased ____ about the same ____ decreased ____ unknown

B. Sources of Funding

1. What are the sources of funds dedicated to MCH activities in FY92? Please estimate the proportion that come from each source below. **(If this information is not known, X here: ____)**

PERCENT (%)	SOURCE OF FUNDS
_____	Grants, awards from the state (e.g. MCH Block Grant, general state funds)
_____	City, county, or other local government funds
_____	Direct federal revenues (e.g. SPRANS projects, 330 funds, federal grants)
_____	Third party reimbursement (e.g. private or other insurance, Medicaid)
_____	Private sources (e.g. foundations, donations, corporate contributions)
_____	Other (please specify): _____
100%	

2. How are third party reimbursement dollars (insurance, Medicaid) generated by your MCH program activities channeled upon receipt in your health department? (X all that apply)
   ____ they are dedicated to MCH programs
   ____ they go into a general fund
   ____ third party dollars are not generated by our MCH activities
   ____ other (specify): _____

4. List in rank order of importance to your health department the five (5) leading MCH problems faced by the families you serve.

Please list only one problem per line. Rank 1 as the most important.

Rank	Problem
1	_____
2	_____
3	_____
4	_____
5	_____

PART 2: PREVENTIVE CHILDHOOD IMMUNIZATIONS

The following questions ask for information about childhood immunization services in your jurisdiction. For the purposes of this survey, immunization services are broadly defined to include administration of vaccines to children, purchase/distribution of vaccine, outreach and education, and other assurance and monitoring activities.

1a. Who are the principal providers of immunization services to children in your jurisdiction? (check all that apply)

_____ city or county health department
_____ community health centers
_____ hospitals: ☐ inpatient ☐ outpatient ☐ emergency room
_____ private physicians
_____ other providers (specify): _____

b. To what extent do these providers collaborate in the delivery of immunization services to children in your jurisdiction?

☐ not at all ☐ very little ☐ somewhat ☐ a great deal

Please give an example(s) of collaboration: _____

_____
_____
_____
_____
_____
_____

2a. Please <u>estimate</u> the percentage of children in your jurisdiction who received primary/preventive child health care from the following providers in 1991:

_____ % from your city or county health department ☐ don't know
_____ % from community health centers
_____ % from hospital - inpatient services
_____ % from hospital - outpatient services
_____ % from hospital - emergency room
_____ % from private physicians
_____ % from other providers (specify %): _____

_____
100 %

b. Please <u>estimate</u> the percentage of children in your jurisdiction who received immunizations from the following providers in 1991:

_____ % from your city or county health department ☐ don't know
_____ % from community health centers
_____ % from hospital - inpatient services
_____ % from hospital - outpatient services
_____ % from hospital emergency room
_____ % from private physicians
_____ % from other providers (specify %): _____

_____
100 %

c. In recent years, some urban communities have experienced a shift from the private to the public sector in the delivery of immunization services. Has this shift occurred in your jurisdiction?

_____ yes _____ no _____ don't know

Why or why not? _____

_____

_____

_____

_____

_____

3. How does your health department administer immunizations to children in your jurisdiction? (check all that apply)

_____ through health department clinics - which one(s):
- _____ immunization
- _____ child health
- _____ primary care
- _____ other: _____

_____ through WIC clinics
_____ through vaccination campaigns
_____ through home visitation programs
_____ through other means, please explain: _____

_____

4a. What immunization guidelines does your health department follow? (check all that apply)

_____ American Academy of Pediatrics
_____ Centers for Disease Control, ACIP
_____ Guidelines set by your State health department
_____ other, please specify: _____

_____

b. What childhood immunizations does your health department currently administer?

_____ DPT, DT
_____ OPV/IPV
_____ MMR
_____ Hib
_____ Td

_____ Hepatitis B: to what groups?
- ___ infants of Hep B+ mothers
- ___ all infants
- ___ infants of refugees and other high risk groups
- ___ adolescents
- ___ other: _____

_____

c. Does your health department plan to provide universal Hepatitis B immunization to children?

_____ yes. If yes, approximately when? _____
_____ no
_____ a decision has not been made
_____ don't know
_____ other (specify): _____

5a. How many children received immunizations and how many doses of vaccines have been administered through all of your health department's programs in each of the past three years?

1991: _____ number of children served _____ number of doses administered ☐ don't know
1990: _____ number of children served _____ number of doses administered ☐ don't know
1989: _____ number of children served _____ number of doses administered ☐ don't know

b. Does your health department currently have the capacity to serve all children who seek immunization services?

_____ yes _____ no _____ don't know

6. In your health department's jurisdiction, what percentage of children are fully immunized at: (Put "NA" if these data are not available.)

	%	What method did you use to determine this percentage?	Are these data available by race/ethnicity?
School entry			☐ yes ☐ no
24 months of age			☐ yes ☐ no

7a. In the past three years, what has been the trend in the amount of funding for your local health department's immunization services?

_____decreased _____ about the same _____ increased _____ don't know

b. Which funding sources below are contributing to your health department's FY92 immunization services? How does the FY92 contribution compare to FY91?

FY92 Funding Source	Briefly Describe Contribution	FY92 $ compared to FY91 $ (X one for each source)
Federal		☐ less ☐ same ☐ more
State		☐ less ☐ same ☐ more
Local		☐ less ☐ same ☐ more
Private		☐ less ☐ same ☐ more
Other (specify): _____		☐ less ☐ same ☐ more

8. **In your opinion, what are the three greatest barriers to age-appropriate immunizations faced by children and their families in your jurisdiction?**

Greatest Barrier _____
2nd Greatest Barrier _____
3rd Greatest Barrier _____

9. **What does your health department need to assure better age-appropriate childhood immunization levels in your jurisdiction?**

_____
_____
_____
_____
_____
_____
_____

10. **Please describe your health department's most successful activities <u>in the past year</u> to improve childhood immunizations levels.**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ABOUT CityMatCH

CityMatCH is a free-standing national membership organization of city and county health departments' maternal and child health (MCH) programs and leaders representing urban communities in the United States. The mission of CityMatCH is to enhance the ability of maternal and child health programs at the local level to improve the health and well-being of children and families in urban areas.

CityMatCH operates under the direction of a fourteen member Board of Directors composed of one representative from each of the ten federal regions plus four at-large representatives, and a Chief Operating Officer.

Since 1989 CityMatCH, with funding from the Association of Maternal and Child Health Programs and the Federal MCH Bureau, has conducted two nationwide surveys of maternal and child health programs in major urban health departments in the U.S.; published and disseminated two documents summarizing the results of the surveys; and held two Urban MCH Leadership Conferences in Washington, D.C. and published proceedings. CityMatCH, in collaboration with the U.S. Conference of Local Health Officers has just entered into a five-year Cooperative Agreement entitled "Municipal MCH Partners" with the Maternal and Child Health Bureau, HRSA. This survey is suported in part by project MCU# 316058-01-0 from the Maternal and Child Health program (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

CityMatCH "regular" membership is limited to city or county health departments in urban areas of greater than 100,000 population. In states where no urban area is greater than 100,000 population, one city or county health department in that state will be granted membership. In addition, any person who has an interest in urban MCH affairs but is not a local MCH director or designee may be an associate member. Currently there are no dues for CityMatCH members.

---

for administrative use only:

City _____
State _____

date 1st mailing _____
date 2nd mailing _____
date 3rd mailing _____

date received _____
org chart attached? ___
materials attached? ___

date coded _____
date entered _____

COMMENTS:

APPENDIX B
List of Surveyed Health Departments[1]

Anchorage, AK
Birmingham, AL
* Huntsville, AL
Mobile, AL
* Montgomery, AL
Little Rock, AR
Phoenix, AZ
Tucson, AZ
Bakersfield, CA
* Berkeley, CA
Concord, CA
* Fresno, CA
Long Beach, CA
Los Angeles, CA
* Modesto, CA
Oakland, CA
Oxnard, CA
Pasadena, CA
Riverside, CA
Sacramento, CA
Salinas, CA
San Bernardino, CA
San Diego, CA
San Francisco, CA
San Jose, CA
Santa Ana, CA
Santa Rosa, CA
* Stockton, CA
Vallejo, CA
Aurora, CO
Colorado Springs, CO
Denver, CO
Lakewood, CO
Bridgeport, CT
Hartford, CT
New Haven, CT
Stamford, CT
Waterbury, CT
Washington, DC
Wilmington, DE
* Fort Lauderdale, FL
Jacksonville, FL
Miami, FL
Orlando, FL
St. Petersburg, FL
Tallahassee, FL
Tampa, FL
Atlanta, GA
* Columbus, GA
* Macon, GA
Savannah, GA
Agana, GU
Honolulu, HI
Cedar Rapids, IA
Des Moines, IA
Boise, ID
Chicago, IL
Peoria, IL
Rockford, IL
Springfield, IL
Evansville, IN
* Fort Wayne, IN
* Gary, IN
Indianapolis, IN
South Bend, IN
* Kansas City, KS
* Overland Park, KS
Topeka, KS
Wichita, KS
Lexington, KY
Louisville, KY
Baton Rouge, LA
New Orleans, LA
Shreveport, LA

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[1]List reflects the principal city within each health department's jurisdiction.

*Did not respond to 1992 survey.

Boston, MA
* Lowell, MA
* Springfield, MA
* Worcester, MA
Baltimore, MD
Portland, ME
* Majuro, MH
Ann Arbor, MI
Detroit, MI
* Flint, MI
Grand Rapids, MI
Lansing, MI
Livonia, MI
Warren, MI
Minneapolis, MN
St. Paul, MN
Independence, MO
Kansas City, MO
Springfield, MO
* St. Louis, MO
Jackson, MS
* Missoula, MT
Charlotte, NC
Durham, NC
Greensboro, NC
Raleigh, NC
* Winston-Salem, NC
* Bismarck, ND
* Lincoln, NE
Omaha, NE
* Manchester, NH
* Elizabeth, NJ
Jersey City, NJ
Newark, NJ
Paterson, NJ
Albuquerque, NM
Las Vegas, NV
Reno, NV
* Albany, NY
Buffalo, NY
New York, NY
Rochester, NY
Syracuse, NY
Younkers, NY

Akron, OH
* Cincinnati, OH
Cleveland, OH
Columbus, OH
Dayton, OH
* Toledo, OH
* Oklahoma City, OK
Tulsa, OK
Eugene, OR
Portland, OR
* Salem, OR
Allentown, PA
Erie, PA
Philadelphia, PA
Pittsburgh, PA
Rio Piedras, PR
* Providence, RI
Columbia, SC
Sioux Falls, SD
Chattanooga, TN
* Knoxville, TN
Memphis, TN
Nashville, TN
* Abilene, TX
Amarillo, TX
* Arlington, TX
Austin, TX
Beaumont, TX
Corpus Christi, TX
Dallas, TX
El Paso, TX
Fort Worth, TX
Garland, TX
Houston, TX
Irving, TX
Laredo, TX
Lubbock, TX
Mesquite, TX
Pasadena, TX
* Plano, TX
San Antonio, TX
Waco, TX
Salt Lake City, UT
Alexandria, VA

Chesapeake, VA
* Hampton, VA
Newport News, VA
Norfolk, VA
Portsmouth, VA
Richmond, VA
Virginia Beach, VA
Burlington, VT
Seattle, WA
Spokane, WA
Tacoma, WA
Madison, WI
Milwaukee, WI
Charleston, WV
Cheyenne, WY

*Did not respond to 1992 survey.